

**A PSYCHOANALYTIC INVESTIGATION OF TRANSFERENCE
MANAGEMENT IN THE IRISH ADULT PUBLIC MENTAL HEALTH
SERVICES**

A thesis presented to Dublin City University for the Degree of Doctor in Philosophy

By

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DECLARATION

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ABSTRACT

A PSYCHOANALYTIC INVESTIGATION OF TRANSFERENCE MANAGEMENT IN THE IRISH ADULT PUBLIC MENTAL HEALTH SERVICES GERARD MOORE

Mental health is a pressing issue for society with approximately 700,000 of the Irish population being affected by a mental health problem over the course of their lives. Despite the extensive demand and the national reformation agenda recent reports indicate that patients are unsatisfied and readmission rates remain consistently high indicating that services do not enable recovery.

Psychoanalysis has demonstrated that to enable positive change it is essential to manage transference. Transference is experienced in the immediate reactions of liking or disliking influential Others; often the subject who we suppose has knowledge that will benefit us. In services this Other is usually the health care professional. Managing transference requires a connection between consciously expressed expectations and unconscious desire. Health care delivery takes place within a therapeutic professional relationship placing responsibility on staff to acknowledge and address the quality of the relationships they have with service users. The reviews of service user satisfaction and the consistent readmission rates indicate that health care professionals are unskilled at forming positive therapeutic relationships. The aim of this study was to investigate the current management of transference and to make recommendation in relation to how recognition and management of transference may have positive outcomes for service users and providers.

Following a review of relevant literature, a qualitative methodology was designed and data collected by interviews and non-participant observation in an acute mental health service. The data were analysed with a Freudian/Lacanian theory of the subject. Findings were grouped under four formulations, transference, language, groups and leaders and resulted in a set of recommendations.

Key findings indicated that the act of caring provokes overwhelming anxiety in staff resulting in the patient being viewed as an object rather than a subject. Transference was unacknowledged and unmanaged and emerged in a negative form which contributed to the mismanagement of critical incidents. Staff appeared more concerned about maintaining the system than engaging with patients. Some professional groups lacked language to describe their work resulting in the retention of patients as minors. Staff spoke for rather than with patients. However with appropriate interventions for staff such as psychoanalytically informed supervision alongside a shift to a post-modern philosophy of care positive change could be achieved.

Chapter 1 Introduction

A process of change has been imposed on the Irish Mental Health Services with an overt purpose of reformation and quality improvement. This study, a psychoanalytic investigation into the management of transference in the delivery of Irish adult public mental health services, argues that the current process of change is more likely to reinforce powerful unhelpful ways of working than to bring about a desirable radical improvement to the system. This claim is based on data generated by the study and analysed using psychoanalytic knowledge on the quality of and attention to the subject–Other relationship, described as transference, the focus of the data generated and analysed. Relationships in the mental health services and society in general are understood as an ego to ego interactive process. Psychoanalysis takes an alternative perspective by preferencing the influence of the unconscious in intra and interpersonal encounters, the terms subject and Other are inclusive of unconscious aspects of human relations. Psychoanalytic research is concerned with the functioning of the unconscious. Service transformation is rarely concerned with intra and interpersonal encounters and when interpersonal encounters are considered the concentration is on ego to ego relationships. This disavows the unconscious of service occupants, consequently service policy transformation enables stagnation and the style of subject-Other relationships enables regression in service occupants. This ensures a steady supply of people seeking mental healthcare and generates sufficient *jouissance* (pleasure that contains a threat)¹ for service delivery personnel to flourish. A paradox of intentionality exists between a conscious overt agenda of improvement and an unconscious covert agenda of stagnation and regression, maintained by shared social fantasy and exhibited via transference in the social reality of service delivery.

This chapter provides an introduction to the study, outlines the structure of this thesis, the methodology and methods employed, the study aims and objectives, relevant historical background of Irish public mental health services structures and an outline of a psychoanalytic position adopted for the study.

¹ See section 2.6 for fuller explanation of this term

1.1 Context for Social Change

The commenced reform in the Mental Health Service is partially the result of the social and political change that has influenced attitudes and approaches to disadvantaged groups in Irish society and should be considered in the context of a country emerging for a lengthy period of denial of social issues. Much of this change has resulted from concerns about the human rights of people requiring placement and treatment when mentally ill. The impact upon the liberty and freedom of the people in mental health services have been a topic of controversial legal and ethical debates for more than 100 years (Salize, 2002). These debates evolve from the necessity to apply coercive measures in certain circumstances, a fact which singularly distinguishes psychiatry from most other medical disciplines. Thus, during the 19th and 20th centuries, different approaches to regulating the application of coercive measures were developed across Europe and all over the world which depend on a variety of cultural or legal traditions, as well as on different concepts and structures of mental health care delivery (Salize, 2002). Since the 1950s and 1960s, changes in the delivery of mental health care, coupled with the achievements of the human rights movement, have shifted the public focus upon a basic criterion for providing mental health care from a paternalistic emphasis upon the need to treat patients who are not able to take care of themselves, to the rights of patients (Salize, 2002). Alongside this the legal frameworks for involuntary placement and treatment have been reformed in many European countries.

‘Nevertheless tendencies for harmonising the concepts and guidelines for mental health care delivery still differ widely all over the world’ (Salize, 2002)p3.

The establishment of the Irish Free State in the 1920’s was followed by a period of civil war and the emergence of a constitution which promotes the values of a particular social fantasy based on a type of family life, heavily influenced by a desire to develop an independent rural idyll where colleens² danced at the cross roads. This fantasy supported by the social reality of economic hardship was coupled with state approved moral sanction that promoted the detention of individuals who did not match the social, mental and moral expectations of society in various institutional

² Irish Language word for young women

settings. Institutional care, a popular method of imposing social and moral control on several sectors of society, was supported by the state, church and general population providing a physical splitting off of the undesirable elements of society and contributed to the backdrop that allowed society to maintain denial about the real social world.

People were confined for a various reasons; criminal activity, pregnancy outside of marriage, poverty, mental health issues, intellectual disability, being orphaned, and physical illness associated with aging and infectious diseases. Institutions in existence before the foundation of the state grew and multiplied becoming the providers of affordable services and employment. Prior to the 1970's the State had 26 public mental hospitals, consisting mainly of large institutions which concentrated on the provision of in-patient care.

This love affair with the institution was the extension of a system inherited from Britain who had political control over Ireland for several hundred years. The Irish asylum system emerged from developments in the conceptualisation and the management of madness common across the British Empire. Foucault (Foucault, 2006) pays particular attention to the birth of the asylum crediting its current form to the work of Tuke in England and Pinel in France. William Tuke founded the York Retreat in England in 1796 to contain and reform the mad, segregating them from the rest of society. Foucault identified during this and the subsequent period of development 'madness no longer exists except as that which is seen' (Foucault, 2006)p487, suggesting that;

'The science of mental illness, such as was to develop in the asylums, was only ever in the order of observation and classification. It was never to be a dialogue. This could only begin once psychoanalysis has exorcised the phenomenon of the gaze, so essential to the nineteenth-century asylum, substituting its silent magic with the powers of language' (Foucault, 2006)p488.

In Foucault's analysis the asylum becomes a place of surveillance and judgement implying the necessity of a standard against which the judgement can be measured.

Tuke took the family as the natural and normal environment and structured the asylum on a re-creation of the principles of family. The family was 'both an imaginary landscape and a real social structure' (Foucault, 2006)p489. The patients, the madmen, were conceptualised as minors and their carers the men of reason, as parents.

'The whole existence of madness, in the world that was now being prepared for it, was enveloped in what we might describe by anticipation as a 'parental complex'. The privilege of patriarchy were revived once more around it in the bourgeois family unit' (Foucault, 2006)p490.

During the 1970's Ireland slowly began to emerge from its economic and social depression, shifting from a predominantly rural agricultural base to an industrial urban society. Becoming a member of the European Community provided a significant economy boost and forced social reform. Consequently many institutional forms of detention and care closed and scandals began to emerge about the moral, physical and sexual abuse perpetrated behind their walls and sanctioned in the name of the state, church and citizens. Within this context the institutional system began to fall into decline.

'The asylum was outside time and ill adapted par excellence. And in this place where animality manifested a presence without history, constantly beginning anew, the immemorial signs of ancient hatreds and ancient family profanations, the forgotten signs of punishment and incest, would slowly surface once more' (Foucault, 2006)p491.

The asylum was a place of the past that maintained the past in the present and constantly renewed itself by having a steady supply of occupants. The decline of the provision of services through institutions concentrating on containment suggests recognition that occupant's needs were not appropriately addressed. However, the scale of the services at that time suggested that mental illness was widespread and the provision of this extensive mental health service was an on-going requirement. Currently the scale of services is changing primarily as a result of an economic agenda.

Financial investment in the mental health services has declined by 66% in the period 1997-2007 (Neville, 2010). This reduction requires a revision of how resources can

be best invested. Additionally the drive towards providing a service that respects the human rights of the individual has led to the reformation of health policy and legislation, much of which is addressed in the current service policy document *A Vision for Change* (Expert Group on Mental Health Policy, 2006). The revision of fiscal investment and mental health care policy are 21st century versions of dancing colleens who instead of Dancing at Lunasa³ now jig and reel at the crossroads of the information superhighway while remaining as blinded by social fantasy as their predecessors. The focus of this study is not the economic structure of the service as an increase in finances would not necessarily lead to an improvement in resource management. Neither is it solely concerned with health and social policy as psychoanalytic research on social policy indicates that policy does not address unconscious elements of social fantasy and consequently fails to bring about social reform (Fotaki, 2010).

Fotaki (2010) argues that public policies frequently fail and what unites most accounts;

‘By policy analysts and organisational scholars is that both policy-making and implementation, and their failures, are assumed to be highly rationale processes. This is despite post-modern social theorist having accepted that welfare subjects pursue multiple and often conflicting goals’ (Fotaki, 2010)p704.

This study focuses on unconscious factors, which provide the theme tune to which society in general and service providers and consumers in particular dance; recognising Fotaki’s (2010) argument that policy making, which contains objectives to improve services, also expresses societal fantasies which originate in the imaginary striving of the subject (Fotaki, 2010)p704. The focus of this research is the transference relationship between individuals which is a product of being inculcated into a pre-existing socially sanctioned group, the public mental health service. The service remains captivated by the jigs and reels of old despite visions for change - the popular River-Dance, because it too is firmly rooted in the unconscious past. The principles of psychoanalysis hold that the unconscious can be found in dreams, jokes, slips, lapsus and symptoms. To understand what is happening in the subject–Other

³ Autumn pagan festival, in which people danced beneath the full moon, also title of Irish play about the structure of early 20th century Irish rural society.

relationship it is necessary to examine mental health service requirements and structures.

1.2 Mental health difficulties

Mental health is a pressing and increasing health issue for society. The World Health Organisation (WHO) (Organisation., 2001) estimates that between one in four and one in five people will be affected by a mental health problem over the course of their lives. If one of every four colleens is out of step the performance of a perfect four hand reel⁴ is impossible. Based on Keogh's (2002) observation that 'one in four families has at least one member currently suffering from a mental or behavioural disorder' (Keogh, 2002)p20 this is equivalent to approximately 700,000 of the Irish population open to a judgment of dancing out of step.

The impact of mental health difficulties on community functioning and resources is consistently underestimated. Indices of health traditionally focus on morbidity and the prevalence of disease. While such measures are meaningful in the context of acute conditions, they are less so with chronic and disabling conditions. This is especially marked for mental health, where disability rather than death is frequently a consequence. It is estimated that almost half of the top ten causes of years of life with a disability are mental health problems, 'namely unipolar depression, alcohol abuse, schizophrenia, and bipolar depression' (Keogh, 2002)p20; statistics that do not reflect the incidence of non-clinical emotional and psychological distress.

1.3 Mental health services

Current service structures are in a process of re-construction rather than deconstruction, institutionalisation rather than de-institutionalisation, a making breaking and remaking of bonds. Public Mental Health Services in Ireland are delivered by the Health Service Executive (HSE) under legislation provided in the *Mental Health Act* (Government of Ireland, 2001a). The *Mental Health Act* (Government of Ireland, 2001a) outlines a structure for the organisation and management and delivery of services by mental health teams managed and led by consultant psychiatrists. Consequently people seeking mental health care are assessed, diagnosed and treated under a patriarchal medical model that commenced

⁴ Traditional Irish Dance

with Tuke's work and that became firmly established to the extent that it's end is impossible to see (Foucault, 2006)p490. Development of the model resulted in a science of observation and classification a criteria for madness outlined in the DSMIV (American Psychiatric Association, 1994). In Foucault's analysis madness creates a double alienation in reference to the family, firstly an alienation that occurs through patriarchy and secondly by the reality of a mental health service which is closely modelled on the family unit;

‘The discourse of unreason becomes inextricably linked to the half-real, half-imaginary dialectic of the Family. And in places where, in their violence, we previously saw profanation and blasphemy, we must now decipher endless attacks against the father’ (Foucault, 2006)p490.

The consultant psychiatrist has become the embodiment of the father within this system and represents;

‘In the modern world, what was once been the great, irreparable confrontation between reason and unreason has become instead the dull thud of instincts repeatedly coming up against the solidity of the institution of the family and its most archaic symbols’ (Foucault, 2006)p490.

Much reform and reorganisation has taken place in the Irish mental health services. The 1945 *Mental Treatment Act* (Government of Ireland, 1945) which introduced a voluntary status for some patients, was considered revolutionary when introduced. In 1982 the Government published a policy document – *Planning for the Future* (Government of Ireland, 1982) advocating a shift from hospital based to community services. Implementation of the policy varied regionally and despite aspirations, institutional practices were transferred into the community. Institutional structures remained in place for the delivery of inpatient acute care and a percentage of medium to long term beds for those with enduring mental health problems. Shifting from an inpatient to an outpatient service took place without a change in legalisation, or the dominant patriarchal structure. Consequently the position reflected what had already been established; that people presenting with mental illness remained in the position of minors and reason for them was given the attributes of the Father (Foucault, 2006)p491. The development of law in which the mad were given the legal structure

of minors to protect them created instead a system enabling control as opposed to protection.

The group ensured that patients as psychological subjects were under the complete control of ‘men of reason, who become for them the incarnation of adulthood’, (Foucault, 2006)p489. The demise reflects a change in social structures, namely the social reality of the demise of the traditional family and a more liberal approach across sections of society which recognised that the traditional family alone does not constitute the only model for social stability and is as much an imaginary as a real social structure. Mental health legislation has been slow to reform and at its heart has not shifted from a patricidal model. Attempts to replace the 1945 *Mental Treatment Act* (Government of Ireland, 1945) were shelved in both the 1980’s and 90’s. It was finally replaced by new legislation with the publication of the *Mental Health Act* in 2001 (Government of Ireland, 2001a).

A significant part of the new legislation was the establishment of the Mental Health Commission (MHC) (Mental Health Commission, 2009) in 2002. The key functions of the MHC are laid down in Section 33 of the Mental Health Act (Government of Ireland, 2001b);

‘One of the core functions of the Mental Health Commission under the Mental Health Act, 2001 is to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services’ (Mental Health Commission, 2012), (Appendix A).

The commission’s responsibilities entail protecting the interests of admissions under the key terms ‘medical’ and ‘standards’; how these terms relate to this study are explored in subsequent chapters. The commission’s responsibilities are framed in the discourses of the Master and the University.

The reformation and institutionalisation process has contributed to legally protecting the human rights of patients, particularly those detained in hospital against their wishes. If we accept the Freudian/Lacanian belief that reform fails to address the unconscious imposing new legislation on an institutional system which is founded in the social fantasy that policy change, the law and medicine hold the key to service

reform, change amounts to little more than a repackaging of the myth of a service equipped to meet the needs of patients. It is the making, breaking and remaking of affectionless bonds around surveillance (observation) and judgement (classification), the imaginary and real social structure of an eighteen century family with the patient in the role of a minor and the consultant with his science of mental illness in the role of father. Current service structures and legal frameworks indicate that a medical/pharmacological model of care is dominant and has constructed services around inpatient hospital and outpatient clinic facilities.

1.4 Medicalised approaches to mental health

Medicalised and largely pharmacological means do not appear, at least on their own to adequately address mental health problems.

‘There were 19,619 admissions to Irish psychiatric units and hospitals in 2010, a rate of 462.7 per 100,000 total population. This is a reduction of 576 admissions from 2009 (20,195). The rate of admissions also declined from 476.3 in 2009 to 462.7 per 100,000 population in 2010. There were 6,266 first admissions in 2010, an increase in the number of first admissions from 2009 (5,972). The rate of first admissions also increased from 140.9 per 100,000 in 2009 to 147.8 in 2010. There was a reduction in the number of re-admissions from 14,223 in 2009 to 13,353 in 2010’ (Daly, 2011)p2.

Table 1 Admission statistics to Irish mental health units 2007-2010

Year	Admissions	First admissions	Readmissions	Reduction on previous year
2007	20,759	5,843	14,916	
2008	20,752	6,194	14,558	-7
2009	20,195	5,972	14,223	-530
2010	19,619	6,266	13,353	-576

The on-going high re-admission rate indicates insufficiency by the current mainly medicalised and largely pharmacological treatments provided. There is likely a connection between the high failure rate of inpatient treatment and the absence of adequate psychological back-up (Browne, 2003)p7. Some attempts are made to address this by the inclusion of biopsychosocial models of understanding and working with mental health issues.

Critical responses to the range and structure of mental health services are evident in inspection reports, consumer consultation and the broader psychotherapy community. Many patients complain about the lack of psychotherapy or psychological treatments on offer which they feel would be of greater help to them than prevalent pharmacological treatments (Keogh, 2002)p20. Several decades of extensive empirical investigation on outcomes arising from counselling and psychotherapy have broadly found counselling and psychotherapy to be effective (Asay, 1999). In about seven out of ten cases, individuals with psychological or behavioural problems who receive therapy make appreciable clinical improvements when compared with individuals with similar presenting difficulties who receive no counselling or psychotherapy (Bergin, 1994).

Recent reviews of service development and delivery are more critical and acknowledge the need for a range of interventions with 40% of patients reporting their experience of services as good and 39% of the same sample reporting that the service did not meet their needs (Crowe, 2004a)p14. In the same study the;

‘Greatest change that people who took part wanted to see is a move towards having more counselling, psychotherapy and other talk therapies available as part of the treatment package, not just in hospital but also in the community’ (Crowe, 2004a)p31.

The *Inspector of Mental Hospital’s Annual Report 2000* (Government of Ireland, 2001b), notes the deficit in the availability of such services. Psychoanalytic research is concerned with both what is said and what remains unsaid. This is highlighted by Menzies Lyth (1989) who argues that it is not always unconscious thoughts and feelings that need our understanding what needs consideration is the impact: ‘what is not being said’ (Menzies Lyth, 1989)p39.

The Expert Group on Mental Health Policy was established in 2003 to prepare a national policy framework for modernisation of the mental health services. *A Vision for Change* (Government of Ireland, 2006) the report of the expert group reiterates the views expressed in the consultation process with services users, carers and providers as well as proposing ‘a person-centred treatment approach’ (Government of Ireland, 2006)p8. A person-centred approach, the humanistic tradition draws directly on the

work of Carl Rogers (1902-1987). Rogers was extremely wary of any attempts to make sense of the unconscious. Rogers expounded an existential approach to life and therapy, where the concern is with living in the here and now and where memories and dreams are seen only as manifest content. Rogers disagrees with Freud and subsequent psychoanalytic theory arguing that;

‘Freud and his followers have presented convincing arguments that the id, man’s basic and unconscious nature is primarily made up of instincts which would, if permitted expression, result in incest, murder and other crimes.it seems to me that I have been very slow to recognise the falseness of this popular and professional concept... the inner core of man’s personality is the organism itself, which is essentially both self-preserving and social’ (Rogers, 2004)p91.

This is in direct opposition to Foucault’s (Foucault, 2006) analysis who argues for an understanding of madness as alienating the purity of a mythical patriarchy, a half-real a half-imaginary dialectic of the Family. Neither does it fit with the more complete understanding of the Freudian position that the id, the part of the subject’s structure which contains basic drives, is superseded by the ego, which has the function of mediating between the id and reality, and the superego, which plays a role in conscience. Both ego and superego are products of development, which in the context of the family and the broader community unconsciously teaches us how to engage in a subject-Other relationship and keep the id in check. Adopting this policy adds to confusion about service philosophy as it contributes to a paradoxical and contradictory approach between the *Mental Health Act* (Government of Ireland, 2001a) and the policy document *A Vision for Change* (Government of Ireland, 2006), with the former promoting a mainly medicalised and largely pharmacological means of addressing treatment and the latter suggesting a person-centred holistic approach. Both the *Mental Health Act* (Government of Ireland, 2001a) and the policy *A Vision for Change* (Government of Ireland, 2006) operate to support social fantasy and ignore social reality. By expounding a person-centred philosophy the *Vision for Change* firmly establishes a block on recognising the unconscious and essential aspects of the subject-Other relationship.

One of the key recommendations of the *Vision for Change* (Government of Ireland, 2006) report is the provision of;

‘An effective community based service, ‘community mental health teams should offer multidisciplinary home-based and assertive outreach care, and a comprehensive range of medical, psychological and social therapies relevant to the needs of service users and their families’ (Government of Ireland, 2006)p9.

The biopsychosocial model views health and illness as exhibiting reciprocal effects among the biological, psychological, and social processes humans are exposed to (Smith, 2000). This is reflected in the *SLAN* 2007 (Barry, 2009) survey which is the largest national survey (10,364 respondents) on the extent of both positive and negative mental health and social well-being in the Irish population.

‘The findings on positive mental health indicate having access to a job, income and good education are all critical to positive mental health, as is having close supportive relationships, affectionate bonds. Recognition of the importance of the social and economic determinants of mental health, as well as the more individual level determinants, points to the need for integrated strategies and intersectional policy initiatives’ (Barry, 2009)p6.

Psychological therapies in the form of counselling and psychotherapy are considered to play a crucial role in promoting both mental and physical health and well-being within the biopsychosocial framework (Organisation., 2001). The findings on psychological distress highlight the importance of accessible community based services, especially for those in socially disadvantaged and low income positions.

‘There is a clear social gradient in evidence for levels of probable major depressive disorder and generalised anxiety disorder, with respondents from lower social classes and lower income groups being more likely to have these disorders’ (Barry, 2009)p6.

Recognition of the biopsychosocial aspect of mental health has greatly influenced the shift from a hospital based to a community based model of service delivery and was originally identified by Freud in his declaration that love and work are the cornerstones of our humanness.

Recognising the need for community based services that address social and psychological needs such as a shift from the observation, classification and pharmacological means of addressing mental health issues to a system that promotes

dialogue, social, psychological and psychotherapy interventions with at least equal vigour, is quite different from enabling its delivery. A social institution such as the mental health service is likely to put blocks in place that serve as a resistance to change. What is at stake here is;

‘The dynamic processes that go on in institutions at both conscious and unconscious levels. Of particular significance are the defences developed to deal with anxiety-provoking content and the difficulties in collaborating to accomplish the common task. These defences appear in the structure of the institution itself and permeate its whole way of functioning’ (Menzies Lyth, 1989)p28.

For any new treatment regime to flourish and have a degree of success there is a requirement that staff accept the intervention and believe that it will have a positive impact. The statistics on admission/readmission rates indicates that despite reform the medical/pharmacological model, even with some integration of biopsychosocial elements, has not significantly improved levels of morbidity. I am proposing that service transformation disavows the unconscious and its influence on the subject–Other relationship, enabling stagnation and/or regression ensuring a steady supply of patients and jouissance for staff and maintaining a paradox of intentionality between a conscious overt agenda of improvement and an unconscious covert agenda of stagnation and regression, maintained by shared social fantasy and exhibited via transference in the social reality of service delivery. The demise of the physical institutions does not guarantee a demise of institutional practices based on control which are a reflection of group behaviour (Freud, 1921a) supported by the institution of the law. It is time to set aside the rigid formal moves of the jigs and reels. This style of step dancing which developed in 18th and early 19th century, at the same time as the adoption of the institution as a form of social care and sanction, became more formalised until it reached its pinnacle in the 20th century form of a universal modern River-Dance. Time instead to consider a Sean-nós⁵ (Meehan, 2010), a

⁵ Sean-nós, the earlier informal dance of the Irish Diaspora, literally meaning old style, is a highly improvisational, low to the ground, rhythmic dance form in which the dancer is free to interpret the music. The dancer is the visual/ percussive expression of the musical tradition and musician and dancer are in conversation. Using hips and arms, the dancer beats rhythmic steps that are closely linked to the music and musician. Traditionally, a dancer danced solo on the hardwood of a half door or the round top of a barrel; as a result the steps are confined to a small space.

psychoanalysis, an individualised rhythm that may throw new light on what can be done at the crossroads of mental health.

1.5 Psychoanalysis and mental health services

In Sean-nós the dancer is free to interpret the music. Psychoanalysis is about interpretation and is a discursive expression of the dance between the conscious and the unconscious. It is about inter-subjective and subject–Other relationships normally conducted on the small space, of the couch.

Psychoanalysis offers an alternative and potentially complementary understanding of the individual and the group and has flourished in Ireland in the education and development of psychotherapist's informed by psychoanalytic theory and practice, yet their services are not a recognisable part of public mental health care.

‘Gaping psychiatric and mental health needs abound in communities of underserved patients around the globe and until very recently it has not seemed likely that psychoanalysts were willing or able to contribute to this challenging problem. This worry still remains, as research from within psychoanalysis that specifically addresses salient public health needs remains sparse’ (Busch, 2010)p307.

It is suggested that psychoanalysis does not appear to have a contribution to make. This lack of a psychoanalytic contribution to the public mental health services contributes to strengthening of unhelpful power relationships that inhibit progress and change. There is a historic context to this exclusion dating back almost one hundred years to an earlier rejection of psychoanalysis by the Irish psychiatric community. This is visible in an exploration of Ireland's history of mental health care by Robbins (1986) quoting an Irish psychiatrist who attended lectures given by Freud in Vienna during the 1920's; ‘I thought he was a little above my head’ (Robins, 1986)p172. Perhaps he wished to hold onto his position in the asylum which is questioned by Freud and subsequently articulated by Foucault (2006) as a position of ‘authority that he borrowed from order, morality and the family he now seemed to derive from himself’ (Foucault, 2006)p508. The association of mental illness with medicine coincided with the institutionalisation of the mentally ill into houses of industry and subsequently asylums in Europe and Ireland. Mental illness came to be constructed as a biophysical illness amenable to medical intervention. The early asylums were

governed by lay people and employed a physician to attend to the inmates medical dominance was soon to emerge. When a lunacy inspectorate was established in 1846 in Ireland the first two inspectors were doctors. According to Robins (1986);

‘The two inspectors set out to consolidate the medical influence on the development and operation of the asylums. Neither had any special experience or understanding of insanity to boost their authority, but little scientifically based knowledge existed at this time’ (Robins, 1986)p92.

Asylums became an integral part of medical progress and a humane way to treat and manage the mentally ill (Rogers, 2005). Foucault (Foucault, 2006) argues that the work of Tuke and Pinel converge in their transformation of the medical character from having no role to play in the confinement of inmates in the asylum, to the role of a wise man with moral and social powers.

‘The doctor could only exert his absolute authority over the world of the asylum in so far as he was, from the beginning, Father and Judge, Family and Law, and for a long time his medical practice did little more than offer a commentary on the ancient rites of Order, Authority and Punishment’ (Foucault, 2006)p506.

The doctor developed a unique relationship the doctor patient couple, a subject–Other relationship.

‘Freud who was the first to accept the seriousness of the reality of the doctor-patient couple, and who consented never to avert his gaze and his research from this link, and who sought not to mask it in a psychiatric theory merely attempting to keep in harmony with the rest of medical knowledge: he was the first to have followed the rigour of these consequences very closely. Freud demystified all the other asylum structures: he abolished silence and the gaze, and removed the recognition of madness by itself in a mirror of its own spectacle, and he silenced the instances of condemnation’ (Foucault, 2006)p510.

Psychoanalytically psychopathology and mental suffering originate from and are imbedded in problematic encounters in the subject–Other relationship. The relationship with the Other is always a problem that needs to be managed. Psychoanalysis is a treatment that operates on and through this relationship, naming it transference. Conducting inter-subjective work without acknowledging recognising or taking transference into consideration, or possibly even not knowing about

transference, amounts to a failure to listen to the unconscious. If the Other does not know where to look for the unconscious, in dreams, jokes, parapraxes, lapsus and symptoms, it is unheard and excluded, as if it does not exist, yet it still has an effect. Unacknowledged transference always has a negative effect. The history of the rate of services change, the failure to articulate and implement a philosophy for mental health services, the past failures to enact new legislation and the *Mental Health Act* (Government of Ireland, 2001a) are interpreted as a defence, a repression of social reality suggesting the opportunity for a psychoanalytic review of the Mental Health Services, specifically a review of the subject–Other relationships it contains.

Menzies (1988, 1989) critiques of hospital services, the Clinic of La Borde (Philbert, 1996) managed by Jean Oury (Reggio, 2007) and subsequently Felix Guattari, (Wolin, 2010) both pupils of Lacan, Main's critique of Hospital Services (Main, 1957) and Freud's Group Psychology (Freud, 1937b) provide evidence that psychoanalysis has a contribution to make relating to the influence of the unconscious on the group and its effects on staff-patient relationships. Within these critiques there is recognition of the unconscious and of the homogenous nature that develops in service delivery dominated by psychiatry. Menzies, (1988, 1989), Philbert (1996), Lacan (1993), Main (1957), and Freud (1937) could all be associated with and dismissed as being anti-psychiatry and pro-psychoanalysis. Oury and Guattari (Wolin, 2010) could additionally be classified as anti-traditional psychoanalytic methods. Dismissals based on being antipsychiatry or non-traditional psychoanalysis are oversimplifications as the position is not either/or but both. A postmodern perspective is wary of absolute truth and holds that multiple approaches contribute to understanding and can conceivably complement each other. The significance and relevance of these theorists is their critical response to and recognition of the need for a dynamic mental health service that addresses unconscious elements of the subject–Other relationship, and recognises the transmission of social fantasy as influential on group behaviour. They argue in favour of exploring, acknowledging and working with the unconscious to improve patient outcomes and the relationship between staff and patients. This study will explore transference in the mental health service and argue that psychoanalysis and psychiatry can both contribute to improved patient and staff outcomes when a critical approach is adopted.

1.6 Constituting nature of the institution

Change is unlikely to occur due to the constituting nature of the institution on the individual without recognition of the impact of the unconscious (Fenichel (1946) cited in Menzies Lyth, 1989, Menzies Lyth, 1989, Menzies Lyth, 1988). This inability to change is promoted through;

‘Significant elements of both content and dynamics held in common by members, derived from a shared external situation and possibly common internal situations, through conscious and unconscious collusive interaction between them’ (Menzies Lyth, 1989)p28.

Arguably regardless of the level of reform at a national level little or no real change will occur locally due to the impact of the unconscious life of an organisation. However if insight into the influence of the unconscious on relationships could be fostered locally in staff, both staff and patients may experience significant change. The constituting nature of the institution influences the dynamic, the transference between individuals suggesting that if a positive constituting nature could be fostered within an organisation, powerful transformations could be brought about.

With a psychoanalytic orientation positive change can be achieved by;

‘Helping insights to develop, freeing thinking about problems, helping the client to get away from unhelpful methods of thinking and behaving, facilitating the evolution of ideas for change, and then helping him to bear the anxiety and uncertainty of the change process’ (Menzies Lyth, 1989)p33.

This requires investigation to see what level of evidence can be produced to support or refute it consequently a research question emerged;

1.7 Research Question

What is the content and implications of transference enactment in the mental health services?

1.7.1 Aim

The aim of this research is to investigate the current management of transference in the Irish public mental health service and to make recommendation in relation to how

recognition and management of transference may have positive outcomes for service users and providers.

1.7.2 Objectives:

- To investigate transference management in the mental health services
- Discover how transference influences the work of services providers and the experiences of those who consume services
- Develop a narrative that expands current formulations of the Irish public mental health service
- Outline a set of recommendations for transference management in mental health services

1.8 The organisation on the couch

The study aims and objectives and the chosen method psychoanalysis, culminates into a study of the organisation on the couch. Through the literature reviewed, observations and interviews, I set out to conduct an analysis on transference enactment. Menzies Lyth (Menzies Lyth, 1989)p34 states that three kinds of analysis can be undertaken; ‘role analysis, structure analysis and work culture analysis.’ Work culture analysis is understood as being the most closely related to psychoanalysis as it considers attitudes and beliefs, patterns of relationships, traditions, the psychosocial context in which the work is conducted and finally how people collaborate in doing the work. Within this context the narratives of those who occupy services are of primary concern and become the data for analysis. In particular, discourse by mental health teams with and about patients will be analysed. The management of transference in relation to patient care will be examined. A psychoanalytic framework will be used to investigate the author’s hypothesis that transference, the subject–Other relationship, remains largely unrecognised and unacknowledged, the consequences of which for service occupants will be considered.

Using psychoanalysis to investigate an organisation differs to how the work of psychoanalysis is conducted with an individual. It is not possible to adopt the traditional approach to an analysis with the patient on a couch;

‘One analyses patterns of relationships (inter-subjectivity) and individual perceptions of organisational experience’ (Menzies Lyth, 1989)p33.

The identity of the organisation is analysed. The researcher adopts an analytic position; is mindful of the history of the organisation particularly in relation to critical incidents. Denial and suppression of the realities of the organisation often go unidentified by members resulting in stagnation in development and a reduction in effectiveness. The purpose of a psychoanalytic research method is to identify and analyse these or other patterns that exist.

‘Psychodynamic orientated organisational researchers explore workers assumptions and attributions that often take the form of defensive projections and distorted images. These projections harm the delivery and content of communication and thus task accomplishment’ (Menzies Lyth, 1989)p213.

The analysis of communication is central to any psychoanalytic study. Diamond (Diamond, 1993), concurs that the psychodynamics of linguistics and communication is central, drawing on the work of Sullivan (1954), Havens (1986) and Levenson (1983) to support his position. Lievrouw (Lievrouw, 2003a) addresses Lacan’s discourse theory as a research tool in that it is;

‘A theory that enables us to formalise the positions that a subject takes within discourse. The word discourse is derived from the Latin ‘discurrere’, which means running around. We run around in a language, so to speak, looking for something that is missing’ (Lievrouw, 2003a).

The work is to look for the unrecognised or missing acknowledgement of transference. Besides psychoanalysis the analysis of narratives emerges from a strong scientific and philosophical tradition;

‘Conversation analysis has its origins in at least two important intellectual traditions. Wittgenstein argued that the social and interpersonal reality that we experience and live in and through is primarily constructed through language. ...Additionally sociologists in the 1950’s and 1960’s decided that the way to understand social life was to analyse the micro-strategies that people use in order to manage interpersonal and group encounters’ (McLeod, 2002)p91.

Foucault (Foucault, 2006) acknowledges that psychoanalysis shifted the science of mental illness from its confinement in observation and classification to a dialogue.

Dialogue began ‘once psychoanalysis had exercised the phenomenon of the gaze, so essential to the nineteenth-century asylum, substituting its silent magic with the power of language’ (Foucault, 2006)p488. However this contains a criticism of psychoanalysis as Foucault (2006) holds that psychoanalysis;

‘Doubled the absolute gaze of the watcher with the indefinite monologue of the surveyed – thus keeping in place the old asylum structure of a non-reciprocity, with the new structure of a language without a response’ (Foucault, 2006)p488.

Freud’s position disputes this by arguing that critics of psychoanalysis;

‘Write as if we had never published a dream analysis, a case history, or an explanation of parapraxes; then, when the evidence is brought to their attention, they say: But that's no proof, that's arbitrary. Just try to show proof to someone who doesn't want to see it! Nothing can be done with logic [.. .] There is no help for it but to go on working [.. .] and let the fruitfulness of our views combat the sterility of those we are opposing’ (Freud, 1907).

Material for the literature reviewed was drawn from a number of sources, Dublin City University Library, purchased text books, online sources and data bases, (CINAHL, Cochrane Library, JSTOR, MEDLINE, Project Muse, PsycArticles, PsycBooks, PsycINFO, Sage Journals online, and Wiley Online library), Government publications and recommended texts by supervisors, colleagues and collaborators. Search terms included psychoanalysis, mental health, transference, subject-Other, groups, and leaders. Lacan’s (Lacan, 1993a) description of the analyst as the subject supposed to know, emphasises the need for the analyst to be reliably informed by an extensive body of knowledge that has been developed by the psychoanalytic clinic. The extent of psychoanalytic literature is vast with Freud’s published papers alone running to twenty four volumes. Consequently the literature reviewed is confined to key authors and key texts containing significant material in relation to transference and a psychoanalytic perspective on group behaviour. The research question and aims resulted in the development of the following structure for this thesis.

Following this introduction the second chapter introduces psychoanalysis under three headings, as a treatment tool, a method of understanding the human condition, a method of investigation and of research establishing the unconscious and in particular

Lacan's discourse theory that structures social reality. Chapter three explores transference and group psychology to create background and support for the thesis. Chapter four concentrates on transference management with an emphasis on essential elements of service provision in the context of groups. Transference enactment in psychoanalytic and mental health settings is discussed. Chapter five details the research methodology. As the study hinges on investigating transference, psychoanalysis was deemed an appropriate methodology both for data collection and analysis. Chapter six describes the method employed for data collection and analysis. The process of collecting and managing data from varied sources, the targeted literature review, non-participant observation, field notes, informal and formal interviews, audio recordings and interview transcripts are outlined. The formalised method of research employed that enabled transference to be explored in a manner meaningful to the domain of research is described. Chapter seven presents the study findings. To provide initial contextual information for the study a brief description of the study site is presented toward the end of chapter 1. Data is organised under two headings, The Settings and Psychoanalytic Formulations which explore transference under four psychoanalytic formulations; Transference, Language, Groups and Leaders, whose separate yet interrelated qualities demonstrate the unconscious's ability to condense and repress intra-psychical material enabling the formation of social bonds. Chapter eight provides a discussion of my thesis under the psychoanalytic formulations used for presenting the findings, with the inclusion of the addition of psychoanalysis to discuss the merits of the methodology. Central to the discussion is a critique of the position that the impetus to restructure services is less about a reformation that would improve outcomes for patients, and more about the continuation of a system for service providers. Chapter nine outlines recommendations arising from the discussion. This includes the recommendation of the development of Balint style groups (Luban-Plozza, 1995, American Psychiatric Association, 1994, Salinsky, 2002, Balint, 1957) in services, a form of psychoanalytically informed group supervision, that concentrates on the management of the subject-Other relationship, that current and future service providers could include in their repertoire of approaches to mental health which would allow the psychoanalytic community to meaningfully engage with service providers.

1.9 The study site

Putting the organisation on the couch involves an analysis of the identity of the organisation (Menzies Lyth, 1989). For this study a research site that incorporated inpatient and outpatient services, a rural and urban catchment area, had engaged in the shift from institutional to community based care and matched the historical profile of delivering public mental health services since before the foundation of the Irish free state was required. This study was conducted in an Irish public mental health service which provides care for a catchment area of 22, 049 people. The Activities of Irish Psychiatric Units and Hospitals 2008 (Daly, 2009)p77 report records 334.6 admissions, 101.3 of them for the first time to the inpatient service during 2008, a 12.2% decrease (Daly, 2009)p78 on the previous year. Two specific areas were used for data collection, the acute admission units and a day hospital.

The construction of a mental health service at the study site commenced at the latter part of the 19th century. This scale of the project speaks to the love affair in Ireland with the building of institutions to contain elements of society. The hospital was built outside city limits in a rural setting with poor public transport access routes that still persist. At the height of its capacity the hospital housed 2,250 patients even though it had been designed to contain a considerably smaller number. Limited distinction was made between those requiring care for intellectual disabilities or mental health issues (Ryan, 1999). Its reputation for the delivery of care in substandard accommodation arises from coping with the excessive numbers of patients in the system. Many patients were housed in temporary wooden buildings originally constructed to accommodate construction workers. These temporary buildings remained as wards until the 1970's and were not deconstructed until the early 1980's. Public outcry or at least public awareness of their existence came following a photo journalist report, 'The Scandal of the Mental Hospitals' (Connolly, 1980). During this period a major reorganisation of services took place including the segregation of mental health and intellectual disability services. During the data collection period the study site had residential accommodation for 139 people, 48 of these places dedicated to the care of people in the acute admission unit (Inspector of Mental Health Services, 2008)p1.

A bird's eye view of national and local developments does not capture the physical structure or social and cultural milieu in which the study was conducted. Studies

concentrating on a single setting raise questions about the possibility of generalising or applying the study outcomes elsewhere. The generated data is setting specific, however the study site is subject to state legislation and the professional groups who operate services do so to the requirements and standards of their professional organisations. Consequently there is a homogenous quality to what can be seen in the study site and what might be found in another Irish public mental health service.

‘What we find with hospitals and educational establishments is that when we pass from one space to the next the *Stimmung*⁶ is always the same: the same atmosphere, the same conditions and the same status. This in turn constitutes the homogenous and ‘ineffective’” (Reggio, 2007)p3.

1.10 The participants

Putting the organisation on the couch involves observing the totality of occupants and events during any observation period. Clinical psychoanalysis is traditionally conducted in the space between two people, the analyst and the analysand. For this study the researcher, who has a clinical background in psychoanalytic psychotherapy and mental health nursing, is in the role of researcher/analyst and the study site in the role of participant/analysand, therefore the data collected during fieldwork, interviews is analysed as if it relates to a single analysand, the institution is on the couch. Individual participants are considered as reliable reflections of the social and cultural context of the group who occupy the mental health services this is possible when the researcher strives to explore significant elements of content and dynamic, patterns of relationships, held in common by group members derived from a shared external situation and possible common internal situations. Much work has been done to protect the identity of individuals who willingly and generously participated, while at the same time potential identifiable militates against a completely anonymous report. The reader is cautioned to keep in mind the analysis of participants speech and actions is the analysis of a shared external situation and therefore a reflection of the unconscious constituting nature of the institution as opposed to a reflection of individual positions.

⁶ *Stimmung* translates as atmosphere in the broad sense of the term.

1.11 Conclusion

This chapter outlined the structure of this thesis by providing contextual, historical and structural data on mental health services and psychoanalysis. National mental health service requirements and critiques have been presented. The current model of patriarchal observation and judgement has been identified. Details of the study site and participants have been given. The constituting nature of the institution has been introduced. My central argument that the current process of change in the Mental Health Services is more likely to reinforce powerful, unhelpful ways of working than to bring about a desirable, radical improvement to the system, is outlined along with the research question, aims and objectives. Arguments in subsequent chapters will show how the process of service transformation repudiates the unconscious and its influence on the subject–Other relationship consequently enabling stagnation and regression. Transference will be explored under four specific psychoanalytic formulations, transference, groups, discourse and leaders. The paradox of intentionality between the conscious overt agenda of improvement and the unconscious covert agenda of stagnation maintained by service providers will be explored. The research aim; to investigate the current management of transference in the Irish public mental health service, is constructed with the firm belief that;

‘Psychiatry and psychoanalysis is an unfinished project, because it is always in construction, a vast field’ (Reggio, 2007)p1.

In mental health services opportunity exists to make recommendation in relation to how recognition and management of transference may have positive outcomes for service occupants. Chapter two explores psychoanalysis as a treatment tool, a means of understanding the human condition and a research method as well as establishing the unconscious and the styles of discourse we run around in.

Chapter 2 Psychoanalysis

Chapter one provided an introduction to the study of transference in the Irish public mental health services. Psychoanalysis was described as a body of knowledge, a form of treatment and a research method and transference attributed with a structuring effect on the formation of a social fantasy that supersedes social reality. The unconscious was understood as operating in and through language and implicating as structuring the subject-Other relationship. This chapter explores in more depth the subject-Other relationship. In order to do this six essential aspects of theory which underpin this research are outlined;

1. The Unconscious
2. Psychoanalysis
3. The subject-Other relationship
4. Lacan's Structural framework
5. Lacan Discourse theory
6. Jouissance.

Psychoanalysis has a multi-dimensional quality with the unique feature that it acknowledges the existence and influence of the unconscious. It is concerned with intra-personal behaviour and in a group context how this influences or is influenced by inter-personal behaviour. Privileging the unconscious sets psychoanalysis apart from other research, treatment, psychological and philosophical positions emphasising that we know things by what they are and through recognition of what they are not.

2.1 The Unconscious

The unconscious and psychoanalysis are intimately intertwined; separate understandings or definitions are possible; however they are best understood in relation to each other. Psychoanalysis is based on a belief in the existence of the unconscious, Freud argues 'that the division of the psychical into what is conscious and what is unconscious is the fundamental premise of psychoanalysis' (Freud, 1923)p19. The repressed (hidden) nature of the unconscious contributes to difficulties in describing and defining it. Freud preferred to identify the unconscious as appearing in our actions bungled and otherwise, parapraxes (slips of the tongue), dreams laden

with manifest and latent content, symptoms and lapsus - the enactment of repressed and often heavily disguised aspects of mental life. It is seen and unseen, heard and unheard, nebulous for as soon as we have grasped it, its form shifts and evades description.

The Edinburgh International Encyclopaedia of Psychoanalysis (Skelton, 2006) defines the unconscious as one of the foundations of scientific psychology an adjective that arises from the idea that though in itself is unconscious and it is also used to describe the way thoughts are forgotten and/or repressed but continue to have an influence on the mental life of the person.

‘As a substantive, and from a descriptive point of view, the term ‘unconscious’ can be applied to elements of psychic life which the conscious cannot spontaneously access. However from a structural point of view, the unconscious system proper is in opposition to the preconscious system in that the mental contents of the latter can be accessible to the conscious by an effort of attention’ (Skelton, 2006)p476.

‘The idea of the unconscious is now so built-in to our cultural thinking that it is very hard for us to imagine what a huge impact Freud’s way of thinking had on society at the time’ (Snowden, 2006)p62.

Freud’s language and structure of the human condition has become the system in which we describe and understand ourselves and others to the extent that we barely recognise our use of it in day to day interactions, ‘it is often used to organise the tangled threads of experience into narrative’ (Bicknell, 2005)p4.

Beyond Freud’s qualitative evidence, progress in the field of neuroscience is promising. ‘The potential for future evidence that may demonstrate through the orderly evolution of empirically tested hypotheses and scientific experiments’ (Peled, 2008)p4, neuro-scientific evidence for the unconscious may be found. This may provide a welcome development in the argument for a quantifiable scientific base for psychoanalysis but it also carries a risk that the subjective experience which psychoanalysis holds as central will become submerged. Lacan highlights linguistic limitations in describing the unconscious arguing that; ‘it seems refutable but is irrefutable’ (Lacan, 2008)p8.

‘The Unconscious...well...it’s the unconscious’ (Lacan, 2008)p7.

He supports the irrefutable quality of speech in that it serves the function of promoting the development of psychoanalysis via a signifier, a name, Freud (Lacan, 2008)p97.

This creates a clear linking between the unconscious and the symbolic, as the signifier Freud evokes something, that it has a prestige in the manner of the name Marx has a prestige which set off a change of associations for the subject (Lacan, 2008)p99. Lacan associates the unconscious with mental distress by reference to Freud’s case histories which taught us that some of his patients were intellectually ill to the extent that we could say they were ‘a bit wrong in the head’ taking care to explain that it is not thought itself that is an illness but that ‘it may make some people ill’ (Lacan, 2008)p101. Thus emphasising the unconscious as a place of thought, which is neither thought nor a place, but never the less where the symbolic has sufficient import to make someone ill.

2.2 Psychoanalysis

Freud (1923) confirms the link that binds the understanding of the unconscious and psychoanalysis as two elements that are inter-dependent in creating an understanding by defining;

‘Psychoanalysis as the science of the unconscious soul (unbewusst-seelish) and the psychology of the Unconscious (Ucs.), which evolved according to the advances of psychoanalysis’(De Mijolla, 2005)p1818.

Freud’s definition below is clear and succinct;

‘Psychoanalysis is the name;

(1) Of a procedure for investigating mental processes which are almost inaccessible in any other way,

(2) Of a method (based on investigation) for the treatment of neurotic disorders

And

(3) of a collection of psychological information obtained along those lines, which is gradually being accumulated into a new scientific discipline’ (Freud, 1923)p235.

Splitting psychoanalysis into three distinct yet interrelated headings is reflected in a later more expansive definition;

- ‘1. As a method of investigation which consists of bringing out the unconscious meaning of the words. The actions and the productions of the imagination (dreams, phantasies, delusions) of a particular subject. This method is founded mainly on the subject’s free associations, which serve as the measuring rod of the validity of the interpretation. Psychoanalytic interpretation can, however, be extended to human productions where no free associations are available.
2. As a psychotherapeutic method based on this type of investigation and characterized by the controlled interpretation of resistance, transference and desire. It is in a related sense that the term psychoanalysis is used to mean a course of treatment as when one speaks of undergoing psychoanalysis (or analysis).
3. As a group of psychological and psychopathological theories which are the systemic expression of the data provided by the psychoanalytic method of investigation and treatment’ (LaPlanche, 1988)p367.

Freud’s (1923) and Laplanche and Pontalllis’ (1988) definitions support the conceptualisation of psychoanalysis as research. However this research draws extensively from Lacanian theory therefore it is also necessary to consider a Lacanian definition creating an additional complication as Macey (Lacan, 1994) argues that Lacan, like Freud, was wary of rigid definitions. However *The Four Fundamental Concepts of Psychoanalysis* (Lacan 1994) appears to be a shift by Lacan towards a more definitive stance. Macey (1994) quotes Freud as suspicious of ‘clear and sharply defined concepts’ on the grounds that ‘the advance of knowledge does not tolerate any rigidity even in definitions,’ outlining Lacan’s critique of Laplanche and Pontalllis’ (LaPlanche, 1988) text as a critical reflection that is too scholastic (Lacan, 1994)pxxx. Additionally Lacan (Lacan, 2008) claims that he never repeats himself, meaning that any explanation, (as opposed to definition), that he offers is over and underscored by what he has said previously and what might yet be discovered. This is less about a failure to define and more a reflection of the dynamic nature of the unconscious and the progression of ideas. A practitioner of psychoanalysis is cautious about solid fixed definitions and much more likely to be open to a perspective that explores the unconscious in the manner that a curious person would watch the waves rushing towards the shore, noting;

‘Each changing place with that which goes before,
In sequent toil all forward do contend,’
(Shakespeare, 1593)p60.

The psychoanalyst is attentive to the dynamic nature of the unconscious and its metonymy, the speed, and sequence of unconscious activity. The unconscious is dynamic, constantly exchanging itself with that which has gone before. This exchange has a pattern, an obscured sequence that can be retrospectively explored while remaining open to an intrinsic nebulous nature of constant change.

Boyle (1990) cited in Crowe (Crowe, 2004b) holds that psychoanalysis is concerned with the unconscious, supported only by a collection of suppositions based on clinical experience. The work of some researchers, (Sandell, 2001, Peled, 2008, Fisher, 1996), indicated an interest in the scientific community in finding a quantifiable bases for psychoanalysis however Verhaeghe (Verhaeghe, 2004) has identified the risk of the subject being submerged in this approach.

Lacan’s unique method of discussing and practicing psychoanalysis remains rooted in a return to Freud suggesting that deviation from the Freudian method and theory is not psychoanalytic. Within this;

‘Any concrete psychology must be augmented by a reference to ethnology, history and law, and that psychoanalysis itself must adapt to the complex theoretical structures that will result from this development’ (Lacan, 1994)pxx.

Ideas for Lacan are drawn from anthropology, philosophy, linguistics, mathematics, the arts and sociology. Attempts to apply psychoanalytic theory to other objects cannot claim to be doing ‘applied psychoanalysis’, since psychoanalytic theory is not a general Master discourse but the theory of a specific situation which fits with Menzies Lyth’s (Menzies Lyth, 1989) description of her research as the analysis of the identity of the organisation. Psychoanalysis is an autonomous discipline; it may borrow concepts from other disciplines, but this does not mean that it is dependent on any of them, since it reworks these concepts in a unique way.

‘Thus psychoanalysis is not a branch of psychology, nor of medicine, nor of philosophy, not of linguistics, and it is certainly not a form of psychotherapy, since its aim is not to ‘cure’ but to articulate truth’ (Evans, 2005)p153.

Lacan’s position cautions psychoanalytic researchers that the application of psychoanalysis needs to remain true to its objective to articulate truth, the truth of the subject, the theory of a specific situation. This position holds psychoanalysis in the place of the clinic and appears to stand against the application of psychoanalysis as a research method elsewhere. However Freud and Lacan used extra-clinical data sources and clinical information obtained from others as ‘an opportunity to question, validate, and elaborate on psychoanalytic theory’ (Vanheule, 2002)p340.

‘Applied psychoanalysis seems to be the domain in which to situate qualitative research. Applied psychoanalysis can be defined as an approach that applies psychoanalytic insight to *extra-clinical data*’ (Vanheule, 2002)p340.

The data for applied psychoanalysis is a set of signifiers obtained from a separate source to the psychoanalytic clinic. In the clinic the analysand seek an analysis unlike the research subject of applied psychoanalysis ‘that did not ask for analysis’ (Vanheule, 2002)p340, with the exceptions of research projects resulting from a tendering process such as Menzies Lyth (Menzies Lyth, 1989). Psychoanalysis from this Lacanian perspective is the articulation of the qualitative truth of the subject.

Within this qualitative paradigm Lacan outlines a structural and a linguistic framework to illustrate the operation of the unconscious.

‘The only significant meaning (scientific and psychoanalytic) we can give to data obtained from interviews is an interpretation that arises from the signifiers and the interconnections between signifiers’ (Vanheule, 2002)p341.

Freud (Freud, 1937a), Lacan (Lacan, 1993a), Menzies Lyth (Menzies Lyth, 1989) and Vanheule (Vanheule, 2002) have systemically questioned extra-clinical data and used psychoanalytic techniques, that is the interpretation of signifiers and the interconnections between signifiers, to delve into the unconscious meaning contained in data.

2.3 The subject–Other relationship

Deliberating on psychoanalysis and the unconscious generates meaning of the terms subject and Other. Lacan names the unconscious as the Other discourse;

‘The unconscious consists of those words which come from some place other than ego talk’ (Fink, 1995a)p4.

Provided there is also consideration of the otherness of language, which is externally imposed upon the subject, language is the language of the Other. The unconscious, structured like a language, is additionally understood, not as something that we are born with but something constructed outside of the self; it has a constituting effect on the structure of the self which ensures the alien quality of the unconscious aiding the processes of repression and denial enabling declarations that something that comes from the unconscious, this other place which is nothing to do with the speaking subject.

Recognising the unconscious exterior quality of the Other allows an examination of an alternative subject to the ego, the conscious subject presented to the world conjures an image of a divided subject split between conscious and unconscious. The conscious thinking of the ego can be understood as rationalisation ‘and the being thus engendered can only be categorised as false or fake’ (Fink, 1995a)p44. This suggests that the true being is something diametrically opposed to the ego however this is not fully the case. The Lacanian split subject is split between ego and unconscious between the false sense of self and the function of language in the unconscious. This divided quality creates a subject (\$) ⁷ represented by two separate parts that do not share a common ground, ‘the subject is nothing but this very split’ (Fink, 1995a)p45. The split subject can be diagrammatically represented by the Mobius strip (Weisstein, 2012), a twisted spiral surface with two sides which alternate as visible so that what is invisible becomes visible at a certain point and what is visible invariably becomes hidden. This describes the appearance/disappearance mechanism of the unconscious addressing its illusive almost intangible quality.

⁷ \$ The capital S with a bar drawn through it is a symbol devised by Lacan to represent the divided subject.

The divided subject (\$) is dominated by the Other so far described as the unconscious and language but there is also the Other that is another being who plays a fundamental role in creating the alienated divided subject. This is observable in the infant who has language imposed upon him from an external Other usually the mother ((m)Other). The Other is another being who has a power over us. In the developing child additional players (father, siblings, careers, teachers, etc.) are imposed upon the imago of the (m)Other. The developing infant progresses from a sense of completeness achieved at the (m)Other's breast to an overwhelming experience of loss and fragmentation at the absence of the (m)Other when she attends to additional aspects of her life. In desiring the sense of completeness the infant sends out a demand to the world which is heard and interpreted by the (m)Other, imposing both a language and a named desire arising from the (m)Other's knowledge on the infant neither of which may match what was asked for. Consequently the infant has no option but to desire to be desired in order to reestablish a sense of completeness.

The Other is the unconscious, language, the (m)Other and later authority figures both real and imagined and the subject is constructed in the split between conscious and unconscious, always alienated, feeling somewhat incomplete, lacking some knowledge and desiring to be desired in order to redress this balance. This fundamental structure of the human condition creates a world in which those who possess knowledge have a privileged position in the unconscious of those who seek it. In this study I argue that the possessors of knowledge in the mental health services fail to recognise their privileged position by a disavowal of the unconscious and operate from an unknowing of the unconscious in an ego to ego discourse, they remain in a powerful position where the subject of their ego discourse will strive to be desired by them and will do nothing but produce whatever it takes, in this case symptoms, to satisfy them. To this point I am building my argument around the unconscious and in particular the understanding of an alienated subject who has a relationship with the Other. This relationship is mediated by internal and external factors including a structural framework comprising of three realms, the Symbolic, the Imaginary and the Real.

2.4 Structural framework

Psychoanalysis, in its approach to understanding the human condition, is concerned with what unconscious mechanisms are coming into play and influencing participants. This is not a devaluing of the lived experience of participants but recognition of Freud's maxim that we are not masters in our own houses (Freud, 1917a). We are conscious of only a small part of our mental activity and a large part of our apparent conscious behaviours and thoughts are driven by repressed unconscious forces which psychoanalysis strives to bring into conscious awareness. To achieve this awareness in a psychoanalytic study with a Freudian/Lacanian approach to the subject the interplay between three mutually dependent registers of mental functioning, the Real, Symbolic and Imaginary which are held together by the symptom is crucial.

2.4.1 The Symbolic

Lacan uses the term Symbolic as a noun describing the work of analysts as 'practitioners of the symbolic function' (Lacan, 1993a)p72. Two particular anthropologists contributed to Lacan reaching this point, Marcel Mauss' (Mauss, 1923) work in relation to the importance of the gift and Levi-Strauss from whom the phrase 'symbolic function' was taken along with his concept that the social world is structured by laws which regulate kinship relations and the exchange of gifts (Mauss, 1923). Foucault's (Foucault, 2006) and Lievrouw's (Lievrouw, 2003b) recognition that psychoanalysis in its preference for language shifted conceptualisation of psychopathology from the phenomenon of the silent gaze to the power of language, resulting in a discourse theory that enabled the identification of the positions that a subject takes within discourse. This demonstrates the centrality of language in psychoanalytic theory and practice. Language is the music to which we jig and jive, transmitting on the platform of our life a discourse that can be interpreted as representational through key steps, notes and rhythms. Central to this concept, language itself is a gift; in the exchange of words we gift speech to each other. According to Mauss (Mauss, 1923) three elements exist in the exchange of a gift; giving, receiving and paying. The person who pays is not always the giver but is frequently the receiver of the gift. In this conceptualisation of the gift the recipient of mental health care pays for the care they receive in the symptoms they produce for service providers.

The Symbolic, being more than language, have real and imaginary elements. Lacan (Lacan, 2008) uses the signifiers 'Freud' and 'Marx' to evoke real and imaginary elements of Freudianism and Marxism. The symbolic element of language is that of a signifier, a word. The signifier does not exist in a positive sense it only exists by virtue of being different to something else, it is known for its difference; for example Lacan refers to the signifiers 'Freud' and 'Marx' as representing two distinct men. An individual's name sets him apart from his fellow man and in addition carries with it subject specific associations. The name Freud is associated with psychoanalysis and Marx's with a particular sociology.

There is 'an intimate connection between speech, Other and language' (Libbrecht, 2001b)p199. The subject-Other relationship is mediated and understood in discourse, the unconscious is the discourse of the Other belonging to the symbolic order. This (m)Other's privilege of attributing a meaning to our first utterances and actions sets up alienation from the self and from desire via language. From Foucault's (Foucault, 2006) perspective we engage in discursive practices that are pre-conceptual yet socially sanctioned, a set of rules govern our perceptions, our judgments our actions, contributing to structuring our unconscious.

The unconscious and language have been imposed from an external source and even though we attempt to claim them as ours they never quite fit. As our awareness of this misfit increases so does our awareness of alienation, lack of mastery of our house, dancing to a tune composed and played by an-Other. Foucault (Foucault, 2006) identified the Doctor in the asylum as an-Other, whose wisdom founded on observation and classification has the mythical power to identify the patient and if he so desires to set the patient free from the chains of the asylum. However a paradox is apparent, if the Doctor discharges the patient he reduces the pool of subjects under his gaze. Language in constructing culture arguably constructs the doctor and the patient.

Psychoanalytic studies on organisational culture carry particular powerful resonance as analysis of the activities of the participants is analysis of the unconscious transmission of site specific aspects of the symbolic order. The language and culture that pre-exists the current participants is transmitted in the roles, structures and work culture in which they operate. This gives access to the attitudes and beliefs, patterns

of relationships and traditions, through the psychosocial context in which the work of an organisation is conducted. Lacan's symbolic order has a universal characteristic, there is a sense that the symbolic order has always existed as a totality;

‘We find it absolutely impossible to speculate in what preceded it other than by symbols’ (Lacan, 1988a)p5.

We are unable to conceptualise what could have existed prior to a world of language without using language, and even when we call language, symbols, to our aid there is a lack or a gap in what we can conceptualise about what if anything previously existed.

‘The universe appears as a universe of discourse. And, in a sense, there will never be anything but a universe of discourse’ (Lacan, 1960-1961)p66.

This failure to conceptualise what existed prior to a set of symbols has implications for an established culture/institution. What existed before it takes on a mythical quality and its very existence, its acceptance within the symbolic discourse almost guarantees its continuation, because to let it go would constitute a new gap in our existence; the subject strives for a sense of wholeness gaps are encounters with the real are therefore intolerable.

The symbolic is imposed upon the subject and ‘provides a form into which the subject is inserted at the level of his being’ (Lacan, 1993b)p179, the signifier allows the subject to recognise himself. The symbolic provides a framework, a dance routine, through which expression takes place. Routine indicates something that is learnt and operates to a formula. The subject has a unique relationship with the symbolic taking the routine of language and refashioning it into individualised Sean-nós steps which are a product of his/her unconscious imaginary choreography. With this engagement in the symbolic the subject gains a set of signifiers utilisable to attempt expression of desire, combating the sense of lack experienced through the alienation that has occurred. For the subject the introduction of the symbolic reverses the positions of presence and absence; ‘absence is evoked in presence and presence in absence’ (Lacan, 1988b)p174. Therefore I argue that for every new service occupant there is a particular symbolic realm, language and structure imposed.

2.4.2 The Imaginary

The Imaginary aspect of Lacan's tripartite scheme is structured by the symbolic, growing out of the language in which we operate. The symbolic order is founded on the signifier, the signified and signification is part of the imaginary order. It is about the meaning and representation attached to the symbolic. The term imaginary conjures up notions of illusion, fantasy and seduction, something we are drawn into. It has its roots in an early part of psychical developed, the mirror stage where again the (m)Other is implicated as the one who points to us in the mirror and says there you are, adding to alienation from the self via language and an external image, linking the symbolic to the imaginary.

‘In man the imaginary is reduced, specialised, centred on the specular image’
(Lacan, 1988b)p282.

The ego forms by identification with its specular image, what is seen when looking in the mirror or at another subject. The visual image causes identification. An occupant of the mental health service is liable to see something of themselves in other occupants. This is an identification with an-other, (a little other, not the big Other associated with the symbolic order), which becomes interchangeable with the ego. This identification with the little other is based on alienation, as this little other or mirror image is from outside of us. We see ourselves as an image, a reflection or as an-other, what we see is not ourselves but an-other. Consequential to this we act as an-other, another staff member of patient.

Alongside alienation there is a strong narcissistic element to this relationship between the ego and the little other suggesting a relation between narcissism and aggression; in the ‘correlative tendency of a model of identification that we call narcissistic’ (Lacan, 1993a)p16. There is a resentment of this apparently complete other that we have identified with. The imaginary is built on an illusion of wholeness, autonomy, duality and similarity allowing us to look at the other and see ourselves, its foundation is primarily in surface appearances, keeping affective structure hidden.

‘And thinking of that fit of grief or rage
I look upon one child or t’other there
And wonder if she stood so at that age -
For even daughters of the swan can share
Something of every paddler’s heritage -
And had that colour upon cheek or hair,
And thereupon my heart is driven wild:
She stands before me as a living child.’

(Yeats, 1926)

Yeats’ (1926) *Amongst School Children* captures elements of this imaginary relationship with the other. He muses that Gonne, his idealised woman, as a child may have been like any other little girl but he confines this musing to her stance and appearance, the image, holding back the affective aspect, the fit of grief or rage. Narcissism allows us to see ourselves in both what the other has and what the other lacks. For Yeats the other shares something of every paddler’s heritage, the physical attributes of the little girl but lacks the elements of the individualised desire of Gonne represented by the fit of grief or rage. The narcissistic element also relates to the subject’s relation to his body, or more precisely because of alienation a mirror image of the body.

Lacan is cautious about any use of the imaginary as a cognitive tool, arguing that we can only understand the imaginary by; ‘recognition of the specular image as a function of something outside the imaginary relation, namely the symbolic’ (Libbrecht, 2001a)p88. The subject has to find some way of symbolising what he imagines. Vanheule (2002) similarly cautions the psychoanalytic researcher against this risk of desire in the imaginary;

‘The researcher’s desire to know or to find the truth will result in an imaginary interpretation of the data. In such a case, the conclusions reflect the researcher’s own prejudices’ (Vanheule, 2002)p340.

Fotaki (2010) argues that public policies are symbolic of the imaginary construction of social reality;

‘Seen from the Lacanian perspective, the key to understanding the idea of a fantasmatic construction of social reality (or the Symbolic Order termed as the Other by Lacan) lies in the imaginary identification of the subject as it acquires its own sense of separate identity’ (Fotaki, 2010)p707.

The subject is searching for an object that never existed, an object *petit a*, the unattainable object of desire which we seek in the Other, ‘which the subject of the unconscious forever tries to recapture through fantasies of wholeness’ (Elliott, 1992)p130. Development of public policy for mental health such as the *Vision for Change* (Expert Group on Mental Health Policy, 2006) could be described as an imaginary social fantasy of a service that would achieve wholeness. This is separate from the social reality of service delivery. The subject, in this case the policy maker, is caught in an endless quest to recapture something, a sense of wholeness. This is a projection by the subject of the internal sense of incompleteness onto an external object of his creation, a social fantasy of a service that can fill all the gaps experienced. By development this social fantasy of a utopia, the policy maker would have created something whole something complete, his desire would be fulfilled. To achieve this utopia the subject draws on available socio-symbolic means, the pre-existing structures of the service, like Tuke’s earlier attempt to recreate the Bourgeoisie Family (Foucault, 2006). The policy maker builds on the examples available to him because he cannot contemplate what existed prior to the present structure. The result is a repetition, a construction of mental health care re-founded on observation and classification deflecting the sense of a fundamental loss.

‘The experience of repeating the (futile) pursuit in order to recover the lost object of the imaginary in the symbolic is unsatisfiable and alienating, but it is the only one that is available to the subject because it does not exist outside the (Symbolic) order of significations. Thus the eternal search for the (Imaginary) sense of self in the (Symbolic) Other becomes the condition of possibility-of desire of human creation and historical action’ (Fotaki, 2010)p707.

The imaginary has tangible magnitude in creating a desiring subject, acting as a defence against the sense of alienation, the failure of the symbolic as a method of expressing desire and against the anxiety of what cannot be articulated, the real.

2.4.3 The Real

The Real is the most elusive of Lacan’s three orders because it is outside of language. The Symbolic denotes the chain of signifiers that make up the Symbolic Order; the Imaginary is structured by the Symbolic, whereas the Real is located somewhere beyond this. The Symbolic is constructed around opposites and lack, and the

imaginary around integration, illusion and seduction. ‘There is no absence in the real’ (Lacan, 1988a)p313, it is complete. The Real is outside language, beyond symbolisation; it is experienced but cannot be articulated. Lacan’s concept of the Real can be linked to philosophical positions, initially to Meyerson’s (Bryson, 2004) description of the real as an ontological absolute which recognises the Real is a true being in itself and later to Hegel’s view that everything which is real is rational and everything that is rational is real. This suggests that it is open to logic and therefore can be calculated in some manner.

‘The Real is not a realm ‘outside’ discourse that can be identified and described, but it is something that operates at a point of breakdown of representation, at a point of trauma or shock that is then rapidly covered over in order that it cannot be spoken of’ (Parker, 2005a)p176.

If the Real is beyond language but is something that is absolute and complete in itself, it has an impossible quality.

The Real lacks the possibility of mediation, it does not have the characteristics of an object therefore ‘all words cease and all categories fail’ (Lacan, 1988c)p164. This is an essential point for research concerned with the lived experience of participants, and for understanding the impossibility of concepts such as empathy in relation to another’s distress. The lived experience for the psychoanalytic subject acknowledges that we are subjects of the unconscious, which we do not have direct access to, and that there is a part of our existence that cannot be symbolised, that falls outside of the realm of language.

The Real has biological links. Lacan’s conceptualisation of the real illuminates the traumatic nature of symptoms of mental ill health. The Real is the object of anxiety; overwhelming anxiety that is experienced by the subject that cannot be articulated because it is an object that does not exist, described by Lacan as the ‘object of anxiety *par excellence*’ (Lacan, 1988c)p164. Similarly Lacan uses the concept of the real to elucidate the concept of the hallucination. Main (Main, 1957) and Menzies Lyth (Menzies Lyth, 1988) identified that some of the behaviour exhibited by staff in health care systems are a defence against the overwhelming nature of anxiety. Menzies Lyth’s (Menzies Lyth, 1988) thesis is that the hospital is unconsciously

associated with pain and death, and death despite its amenability to calculation and logic, evokes an existential crisis that takes us beyond both the Imaginary and Symbolic order to a place beyond articulation. Main's (Main, 1957) work outlines the search for a chemical solution, the administration of medication, an attempt to address something psychological via a biological route an intervention to the body of the patient, when staff are confronted with an excessive quantity of their own and patients anxiety.

The Symbolic is externally imposed on the subject, the Imaginary comes about by the subject engagement with the specular image, and the Real has both internal and external elements. Adopting Meyerson's (Bryson, 2004) position, the Real is a true being in itself therefore external to the subject. However, Lacan's use of the Real to elucidate symptoms such as anxiety and hallucinations suggests an internal quality. Attempts to understand and integrate the interplay of internal and external elements are made via the Symbolic, via language highlighting the centrality of a linguistic framework as the only system through which we can arrive at a shared understanding of the human condition. Signification can only come from interpretation of signifiers and the interconnection between them resulting in the location of understanding in a linguistic framework.

2.5 Discourse

The science of mental illness shifted from a confinement in observation and classification to dialogue when psychoanalysis replaced the silent gaze with 'the power of language', (Foucault, 2006)p488. This introduction of language as a powerful tool in the construction of the individual emerged from Freud and Breuer's early work with patients and is traced back to the concept of psychoanalysis as a talking-cure (Breuer, 1893b)p30. Freud recognised the importance of language and transference in the subject-Other relationship. He identified speech as a route towards the relief of symptoms and transference as having a nuisance quality that interferes with progress in therapy. Language for Freud had a magical transforming power and he later credits this transforming power with having an influence on group behaviour.

‘A group is subject to the truly magical power of words’
(Freud, 1921a)p80.

This magical power of words is repeated in how the words of a leader/big Other can influence the affect experienced by the group. There is linkage between the Symbolic order in the formation of the individual, in the creation of the Imaginary, as the medium for psychoanalytic practice and as an unconscious influence on the group by the leader.

Freud and Breuer's (Breuer, 1893a) work, *Studies in Hysteria*, highlights a linkage between language and transference. Transference, a measurement of the quality of the subject-Other relationship, an enactment of the libidinal drive, resulted in Breuer abandoning Anna O., because her declaration of desire was overpowering. Freud holds that language has carried out an entirely justifiable piece of unification in creating the word love, which has its roots in the libidinal drive and is implicating in the formation of social bonds. Signifiers from a Lacanian perspective structure the subject.

'The basic idea fundamental to Lacan's perspective, is that both our observations and our thoughts are structured by language' (Gylos, 2002)p69.

The signifier love is entwined in the libidinal drive and particularly associated with the formation of couple relationships, the imaginary of courtly love and the real of the sexual relationship, intimate social bonds. This inhibits our ability to freely use the term in other contexts where intimacy is prohibited and formal relationships prescribed. Consequently language is used to express desire in a sociably prescribed pressure to conformity (Freud, 1921a, Lacan, 1993a, DeBoard, 2005), making the expression of desire in an institution a taboo which will almost certainly be maintained by the staff.

This social prescription is identifiable in Lacan's discourse theory which outlines four discourses, Master, University, Hysteric and Analytic as the four styles of social bonds, subject-Other relationships, transferences that determine the social functioning of an institution. The four discourse are Lacan's description of the nature of social order, what binds society together, his way of structuring social interaction, they represent the fundamental elements of social reality (Novie, 2008). Psychoanalytic practice is founded in the symbolic function and understood for this study as operating

within Lacanian discourse theory. Language, the precondition for discourse has to exist prior to any form of communication, however, discourse from a Lacanian perspective is not simply a matter of communication (Loose, 2002). Communication, talking, always contains a lack demonstrated in the impossibility to articulate subjectivity. Speech is an attempt via the Other of language to address the experience of lack which commenced when the subject entered the symbolic order and at the same time founding via language a social bond. This lack results from the loss of jouissance and is protective to the subject.

‘Discourse is a form of protect: it protects against the death-drive’ (Loose, 2002)

Discourse prevents the annihilation of the subject, by fostering desire and keeping jouissance at bay. The desire of the Other, which is unknown, creates anxiety in the subject. Discourse operates as a way of negotiating with the Other, it is an attempt to orientate to the Other’s unknown desire. In this manner desire is translated into demand which is negotiable (Loose, 2002).

2.5.1 Four discourses

Lacan represents each of the four discourses by an algorithm; these algorithms are an aspect of Lacan’s project of formalisation called *matheme*.

‘The word *matheme* is a contraction of Levi-Strauss’ *mytheme* and the Greek word ‘*mathema*’ (knowledge). It is a generic term that refers to Lacan’s different algebraic formulas’ (Vanheule, 2002)p337.

With these formulas Lacan presents a contemporary interpretation of Freud’s ideas providing a framework that enables dialogue between psychoanalysis and other disciplines. To explain the four discourses, Lacan’s theory of social order, he created four algorithms utilising algebraic symbols;

S1 = The Master or first signifier; represents prohibition, a statement of no, and is responsible for the subject coming into being. This signifier is a trait from the symbolic and causes the subject to exist (Loose, 2002).

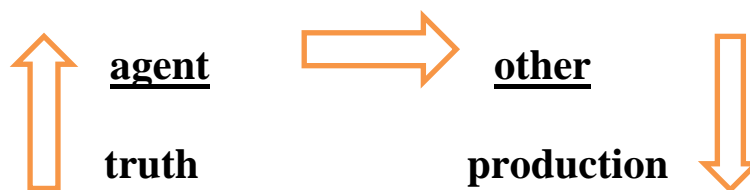
S2 = Knowledge or all other signifier in the chain of signifiers.

\$ = The divided subject as described by Freud. The division is brought about by language (Grigg, 2001).

a = relates to surplus jouissance which can be understood as both more and no more. There is an enjoyment in repetition even if it is around something that has been lost (Lacan, 2007).

In each discourse the symbols retain the same order but shift a quarter turn within the algorithm. Diagram 1 below demonstrates the structure for the discourses, outlining four fixed places through which the terms above rotate. This enables the representation of the four discourses. The position below named the agent is considered dominant in each algorithm.

Figure 1 Lacan's algorithm



2.5.1 The Master's Discourse

Figure 2 Master Discourse

$$\frac{S1}{\$} > \frac{S2}{a}$$

In the Master discourse, the master signifier (S1) is in the agent position. This primary discourse is fundamental to the subject's being in the world through the alienation which occurs with the frustration of desire when the subject enters language. The dominant master addresses the subject (slave) who works for and produces something in terms of knowledge for the master.

‘The master must be obeyed – not because we would all be better off that way or for some other rationale - but because he or she says so. No justification is given for his or her power it just is’ (Fink, 1995a)p131.

The master discourse is a desire to master knowledge. The other, as slave, has to work for the master and produce something for the master to enjoy. In reality the master has no great interest in what the slave produces. His interest is confined to the slave working for the master. This appears contradictory, however, as described by Loose (2002) not wanting to know is not incommensurable with wanting to master knowledge (Loose, 2002)p243. Knowledge is important to the master as it gives him a status allowing him to remain in the master position.

‘Not wanting to know is not incommensurable with wanting to master knowledge. What is important to the master is that he possess knowledge so that he can maintain his position in order to master the situation’ (Loose, 2002)p243.

Through the application of the master discourse to services we can conceptualise the patients' symptoms as products that fuel the system. Symptoms as products have a surplus quality. The symptoms are of no great interest to staff as they only confirm the knowledge that there is an abundance of people with mental ill health that will require services in the future. This conceptualisation put the staff in the place of the agent and the patient in the place of the other with symptoms and jouissance taking the place of truth and product. There is no interest in the symptoms beyond the jouissance they give staff, therefore no interest in the truth of the patient.

Figure 3 Master Discourse in Services

$$\begin{array}{ccc} \underline{\text{Staff}} & > & \underline{\text{Patient}} \\ \text{Symptoms} & & \text{Jouissance} \end{array}$$

Taking this idea a little further begs the question about what sets the staff apart as being different from the patients. Staff operating from a Master discourse conceal via an authority based on nothing more than adopting a master position, they are also divided subjects no different from the patient. Why then do the patients not revolt and question the authority of staff; for two reasons. Firstly staff utilise the law and knowledge to assert their position and secondly the master operates as the ego ideal for the other. The discourses do not operate in isolation from each other. In this respect the Master Discourse utilises the University discourse (knowledge) to augment its status. Additionally staff's authority began according to Foucault (Foucault, 2006) when the Doctor entered the asylum with an absolute authority as Father, Judge, Family and Law. The Master discourse is alternatively the discourse of the law. We are all subject to the law, when we break the law it carries with it a threat. A real threat in terms of a sanction or a punishment or withdrawal of services, punishment operates like castration. By recourse to the law staff can exercise real power over the patient. The *Mental Health Act* (Government of Ireland, 2001a) is the pinnacle of this ability to castrate with its statutory power, to detain and physically treat a patient. The power to detain the patient is shared amongst different grades of staff, whereas the power to treat is limited in most circumstances to the Doctor.

To contain this master position the system is designed with a series of checks and balances, subjecting staff to the law; this indicating recognition that unlimited power is problematic. Incidents of where the role of regulation has been lacking and the Doctor has been able to operate as the ultimate primal father lead to a total subjection of the patient such as actual castration by unnecessary peripartum hysterectomy which rendered a series of patients infertile (Harding Clarke, 2006).

Within the hierarchy, around which services are organised, the more senior the staff member, the less they have to do directly with patients for a greater enjoyment. In Freud's and Lacan's theories there is a conceptualisation of and;

‘Insistence on the existence of an ultimate authority, namely the primal father, from whom every father inherits his power’ (Verhaegehe, 2009)p15.

This ultimate father or Big Other, has nothing to do but enjoy the surplus jouissance produced. The asylum structure (Foucault, 2006) with the Doctor as a fountain of wisdom and in the role of father emphasises this role as primal father/Big Other with other team members and patients subordinate to his power.

2.5.2 The University Discourse

Figure 4 University Discourse

$$\frac{S2}{S1} > \frac{a}{\$}$$

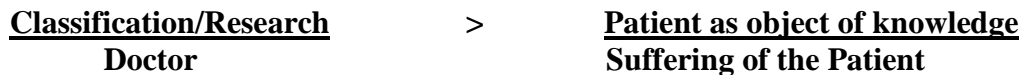
In the University discourse, knowledge, the chain of signifiers (S2) takes the dominant position. This is about a desire to master the object. This results in the production of general knowledge and a self-perpetuating project as ‘the more knowledge is generated to grasp the object, the further this discourse moves away from reaching its aim’ (Loose, 2002)p247. Lacan positions the modern form of discourse of the Master under the discourse of the University reasoned by the role that bureaucracy plays in the modern capitalist state: knowledge, as the all-knowing dimension of modern bureaucracy, is the dominant position of the agent.

‘Thus bureaucratic capitalism has the structure of the university’
(Grigg, 2001)p69.

University discourse would formally have been a production of the Master discourse, it plays the role of legitimating the discourse of the master, it rationalises the will of the master. In the university everything can be explained, nothing is left outside of the requirement for definition, explanation and justification. University discourse serves the staff and patients of the mental health service in their need of a justification, explanation and rationalisation for their work and symptoms.

In the University discourse classification/research take the position of agent. The patient becomes an object of knowledge and the truth is located in the doctor/researcher with the patient's suffering understood as the product of the discourse.

Figure 5 University Discourse in Services

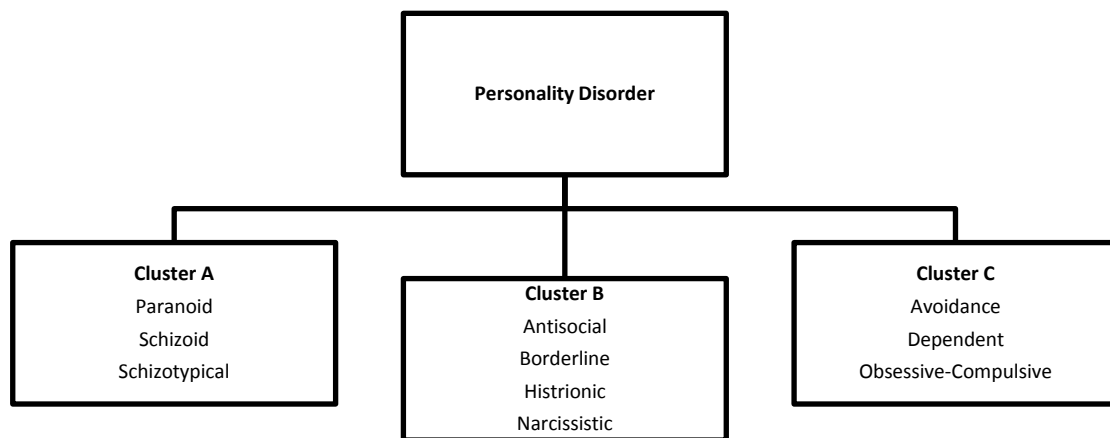


Knowledge is a defence against the truth, product - the generation of knowledge, is preferred over the unconscious.

‘It implies that the kind of knowledge involved in the university discourse amounts to mere rationalisation, in the most pejorative Freudian sense of the term’ (Fink, 1995a)p132.

University discourse has the knowing subject as its agent and the unconscious is a product which remains excluded. It does not come to terms with the real of the world, striving instead to catalogue every aspect of it. The multitude of conditions described in the DSMIV (American Psychiatric Association, 1994) lends support to this argument. For example a category from the DSMIV such as Personality Disorder (PD) is immediately suggestive that the overall category PD can somehow be measured against a normal personality; therefore a continuum of normal to abnormal exists. The category PD has three subsections, which are further divided into diagnostic categories. However the three clusters and ten diagnostic categories still fails to account for all possible presentations of PD so an additional option for categorisation, nonspecific personality disorders is required. Knowledge does not provide a total solution it only leads to the identification of the something left over, fuelling the University discourse and the search for something even more miniscule, something beyond nonspecific personality disorder, creating its own infinite regress.

Figure 6 Classification of Personality Disorder



(American Psychiatric Association, 1994)

The University discourse provides a cover up, an illusion of knowledge for the authority of the Master discourse. The subject is a knowing subject of conscious knowledge that excludes the unconscious; Lacan closely links the University discourse and science a position augmented by the conversion of practical knowledge to theoretical knowledge.

‘Philosophy has filled the function of depriving the slave of his or her knowledge and making it the possession of the master’ (Grigg, 2001)p69.

With a University discourse practical knowledge, the technique of the slave is converted into theory which becomes the pure knowledge of the master.

‘The discourse of the university is the discourse of science’ (Loose, 2002).

For example mental health nurse education shifted in the latter part of the 20th century from an apprenticeship model based on practical knowledge and learning by experience in a healthcare setting to a university based degree programme delivered by university staff, the experts or masters of the profession. These experts are only in a position to deliver a general knowledge about the people who require mental health services. Additionally service staff are purveyors of a University discourse that serves

a master position, the patient's symptom, his subjective technique for managing anxiety, are observed, categorised and converted into a theoretical knowledge which is then located in a list of signs and symptoms in the DSMIV (American Psychiatric Association, 1994). Symptoms can then be justified, rationalised and explained by a subject supposed to know.

2.5.3 The Hysteric Discourse

Figure 7 Hysterical Discourse

$$\frac{\$}{a} > \frac{S1}{S2}$$

The Hysterical discourse sees the subject (\$) taking the dominant position and represents the desire to master the master. According to Loose (2002) everybody who speaks, that is functions in language, finds themselves in a hysterical position as desire is the foundation of hysteria (Loose, 2002)p244. The term discourse of the hysteric conjures up images of psychopathology and Charcot's performing patients (Marshall, 2003).

'Hysterics have been a true motor force behind the medical, psychiatric, and psychoanalytic elaboration of theories concerning hysteria. Hysterics lead Freud to develop psychoanalytic theory and practice, all the while proving to him in his consulting room the inadequacy of his knowledge and know-how' (Fink, 1995a)p134.

The hysteric places a demand on the Other to supply a satisfactory answer, a total explanation about a phenomenon. However what Lacan is endeavouring to get across is not just what the hysteric says but the social bond in which any subject may be enrolled. This social bond is characterised by a demand that we speak, that we answer a question, even if the question is not asked and in the knowledge that we do not have a complete/satisfactory answer.

'If hysteria is a set of statements about the hysteric, then the hysteric is what eludes those statements, escapes this knowledge. Moreover, beyond the properly scientific attempt to master an object through knowledge and thus to reduce it to a body of statements, the history of hysteria bears witness to something fundamental in the human condition - being put under pressure to answer a question. The questioning one is the hysteric. Asking a question is so

elementary a relation of language that it can be done without words: when the hysteric presents her riddled body to the physician, even though mute, she poses her question' (Wajcman, 2003).

The discourse of the Hysteric is motivated by the impossibility of the Real, which defies the symbolic. The hysteric addresses a master attempting to get him/her to produce knowledge.

'This discourse is very productive in that it results in the accumulation of knowledge (S2)' (Loose, 2002)P244.

If the Other grants the hysteric's demand for knowledge they are inundated with additional demands. Testing behaviour of this nature is well known to analysts and the providers of mental health services, it relates to the hysteric's attempt to ascertain the analyst's or service provider's desire and knowledge.

'The hysteric tries to discern the Other's desire in order to be able to position herself in such a way as to become its lack or cause' (Fink, 1999)p133.

The hysteric pushes the master to a point where his/her knowledge fails. This scenario is acted out again and again in services, the patient demands knowledge about their condition from staff, knowledge that they do not have, but they attempt to furnish it due to the power of the demand and therefore fail to satisfy the patient. Additionally staff appeals to the doctor as master, for total and ultimate knowledge that he does not possess but never the less is required to produce. The hysterical discourse cannot be mastered by knowledge; it demands speech but also defies it because what it asks for cannot be articulated.

Figure 8 Hysterical Discourse in Services

$$\frac{\text{Hysteric Patient/Staff}}{\text{Symptoms}} > \frac{\text{Doctor/Master}}{\text{Knowledge}}$$

Lacan 'located science with the discourse of the hysteric' (Grigg, 2001)p70. In the Master and University discourse we can see that knowledge is used to justify

authority. Knowledge has a utilitarian function for the master and an eroticised function for the hysteric.

‘The real driving force behind the hysteric’s discourse is the impossibility of the Real; the same goes for pure science, for quantified science. and in so far as science is motivated by the impossible, it has a certain relationship to the discourse of the hysteric’ (Grigg, 2001)p70.

Fink (Fink, 1995b) argues that hysterics are like good scientists;

‘They do not set out to desperately explain everything with the knowledge they already have – that is the job of the systematiser or even the encyclopaedist – nor do they take for granted that all the solutions will be someday forthcoming’ (Fink, 1995a)p134.

While knowledge cannot articulate the hysteric, the hysteric steers the master to articulate knowledge (Wajcman, 2003), thus the demand, the question the hysteric poses is vitally important. This is paradoxical because hidden in this demand is the historical lesson that we continually fail to learn, an answer is not forthcoming. The discourse of the hysteric with its demand for an answer is failed by the master’s authoritarian response and the university general knowledge response.

2.5.4 The Analyst’s Discourse

Figure 9 Analytic Discourse

$$\begin{array}{c} \underline{a} > \underline{\$} \\ S2 & S1 \end{array}$$

In the discourse of the Analyst the dominant position is held by surplus enjoyment (a) and for the first time the subject appears above the bar with the master below, a complete reversal of fortunes.

‘Within the transference the analyst becomes the addressee of the symptom’s hidden message and, through interpretation, the analyst inserts the communication back into discourse. Operating solely by means of speech, analysis reconstructs the continuity of the subject’s history through retroactively giving meaning to opaque elements in the subjects discourse’ (Grigg, 2001)p63.

The discourse of the analyst represents a desire to master the subject but in a way that is opposite to the master discourse. It is a desire to produce difference and is therefore not about a general knowledge, instead it is about subject specific knowledge. The driving force behind this discourse is the analyst's own knowledge of his desire and jouissance (Loose, 2002) which must be kept separate from the discourse of the analyst. The analyst recognises that even though he is the subject supposed to know for the subject, he must keep his knowledge separate so that he can listen in a particular manner to the subject's speech. The analyst has to function as object (a) to provoke the desire of the subject (Loose, 2002). Analysis involves unfreezing 'signifiers previously excluded from any dialectical process' (Grigg, 2001)p66. To enable this process the analyst must during the analysis become the cause of the analysand's desire.

This is a radically different from the master discourse there is no attempt at mastery or dominance over the patient. This allows the analyst to work with the signifiers that emerge in the analysis without directing the subject. This approach aims to allow the relationship of unconscious fantasy to be at the forefront where it can be explored in the space between the analyst and the subject.

'The position of the analyst in the discourse of analysis provokes the transference and maintaining that position allows the transference to develop' (Loose, 2002)p246.

If this analytic position is maintained the subject, who has been encouraged to speak freely, can produce knowledge that is akin to the truth of their subjectivity. This subject specific knowledge relates to the individual's experience of jouissance.

Figure 10 Analytic Discourse in Services

$$\frac{\text{Analyst}}{\text{Knowledge}} > \frac{\text{Analysand}}{\text{Symptom}}$$

The Master, University and Hysteric discourses are concerned with conscious knowledge and the Analytic with unconscious knowledge, knowledge entwined in the signifying chain that the patient does not have ready access to. Analytic discourse is about creating movement, 'where that knowledge was, the subject must come to be'

(Fink, 1995a)p136. This maxim is an affront to the Master, University and Hysteric discourses of services, the position of the subject supposed to know and its attempts to affect a cure through observation, categorisation, medication, psycho-education and a demand for recovery. Analysis enables the subject to perceive that they are not master in their own house, they are divided subjects not fully in charge of their discourse, there is another speaking which is nothing less than the speech of their unconscious.

2.6 Jouissance

Jouissance has been referred to above in my exploration of Lacan's discourse theory and in chapter one was identified as the experience of pleasure that contains a threat, a simplistic and insufficient definition. Attachment to the (m)Other is marked by jouissance, a jouissance of the body of the Other as the infant is a primitive, fragmented being existing on a somatic level. There is a pleasure in the sense of completeness, inclusive of potential annihilating anxiety. Once the developing infant enters the symbolic order, a shift from purely somatic to psychic existence occurs and through alienation by language the impossibility of completeness is established. The desire to feel complete and whole, to submit to being the desire of the (m)Other provokes anxiety. Jouissance lacks a direct English translation but refers to extreme threatening pleasure.

‘Sometimes it is translated as enjoyment, but enjoyment has a reference to pleasure, and jouissance is an enjoyment that always has a deadly reference, a paradoxical pleasure, reaching an almost intolerable level of excitation’ (Levy-Stokes, 2001)p101

Jouissance is linked with excess, the excess of sexuality (libidinal drive) and death (death drive). The signifier both causes and limits jouissance. The lack of language to articulate everything indicates a beyond language an experience, a totality, a real outside of the symbolic order.

This effects how we function, the sheer impossibility of an absolute articulation is an issue for everyone but acutely experienced by the mentally ill. Jouissance mandates repetition of something from the past and is always experienced as failure or loss. We constantly attempt to fill this gap. In contemporary health services staff are

encouraged to take a holistic approach to care planning (Health Services Executive, 2012)p93 in the naive belief that holistic solutions are possible and desirable, a disregard of the impossibility of completeness.

Menzies Lyth (Menzies Lyth, 1988) found that the nurse is equated with the early imago of the mOther, making the body of the nurse a potential source of jouissance for the patient. The nurse is subject to the patient's often hysterical demand. Menzies Lyth (Menzies Lyth, 1988) recognised that individuals when they joined nursing services used identification with superiors (ego ideals) and peers (ideal egos) to protect themselves from the anxiety provoked by the demand of the patient for satisfaction of jouissance. The identification with anOther in a superior or powerful position offers protection from the demand of the patient but can be polarised as an experience of love or hate for the other in the social world of the nurse. I hold that Lacan's description of identification with the image of the self in the mirror occurs between nurses. Nurses are subject to the anxiety provoked when faced with new and challenging situations and their unconscious concept of self is challenged by the work. There is every reason to assume that they experience alienation and see something in others specular images, allowing them to develop a shared style of operating. Staff operate from a Master discourse and repress anxiety, regressing to primary defences to manage social bonds. Main's (Main, 1957) findings indicate that the regression in staff when they join a system with an established culture, results in established staff reverting to previous less helpful coping mechanisms to guard against anxiety. Staff, in order to survive the overwhelming demand; curtail the desire to destroy the demanding patient by establishing an ego ideal/Big Other who can satisfy their desire.

2.7 Conclusion

This chapter reviewed relevant aspects of theory relating to the unconscious, psychoanalysis, the subject-Other relationship, Lacan's structural framework and discourse theory and jouissance. Although definitions have been provided, the work of Freud and Lacan alerts us to the dynamic nature of the unconscious and the need for all descriptive endeavours to take into account past, currently and potential knowledge promoting a dynamic understanding as opposed to solid irrefutable definition.

Acknowledging the unconscious acknowledges lack of mastery over and access to much mental activity. Lacan's structural framework provides a construction enabling understanding of the subject's relationship with the world. This relationship is mediated through four social bonds, outside of which it is impossible for the subject to exist. The signifier love, with its roots in the libidinal drive, has a particular place in the formation of subject-Other relationships, and is manifest in the articulation of desire observable in transference. Chapter three presents a review of a Freudian/Lacanian understanding of transference. The symbolic and imaginary allows for the subject to mediate their relationship with the Other and seek expression and satisfaction of desire. Desire is essentially the desire to be desired and its expression is inhibited. Elements of desire and anxiety can be experienced as overwhelming and threatening defying symbolic representation they are experienced as the Real. The signifier causes and limits jouissance.

To this point I have mainly concerned myself with the subject's relationship with the Other from a structural perspective this is expanded in the next chapter by the inclusion of transference. Additionally chapter 3 examines psychoanalytic conceptualisations on transference and group psychology.

Chapter 3 Transference and Group Psychology

This chapter explores transference and group psychology. Group psychology exemplifies how non-acknowledgement of transference and the influence of the group on the individual results in a particular style of behaviour. This style of behaviour is acted out by group members as they are subject to the powerful influence of the group and often dependant on the leader. In this chapter I argue that the mental health service group is cut off from truth and reality and operating through illusion which contribute to the stagnation of services and regression of service occupants. Chapter two introduced the structuring effect of language in subject-Other relationships and demonstrated the unconscious as a psychical process that is visible in our actions/inactions. This argument is expanded here by exploring how inaction or transference mismanagement contributes to acting-out.

Transference, like the unconscious, is established as part of our general vocabulary and has been adopted by numerous psychotherapy models, psychology and psychiatry. The first sections of the chapter explore the origins and mechanism of transference and the structuring effect it has on subject-Other relationships. The articulation of transference as love and its direct connection to the instinctual drives is examined. The power of demand and countertransference are explored. Evidence on how the subject-Other relationship develops as the subject expands its primary singular relationship to the (m)Other and is socialised into groups expands the discussion from exploration of transference in a dyad to its enactment in groups.

The transition from individual to group psychology and the roles played by transference and identification in creating and maintaining social bonds is presented as transference enactment in staff – patient relationships. This necessitates that elements of group psychology relevant to this study are explored. These elements, identification, the ego ideal and ideal ego, truth and illusion are explored alongside consideration of the role of the group leader.

3.1 Transference

Transference is generally understood as the attribution of the qualities of a significant person from the past onto a person in the present, sometimes without taking

unconscious elements into account. Transference proper is concerned with the unconscious aspects of the subject-Other relationship. In relationships we experience strong and powerful affects that influence likes, dislikes and the quality of interactions. When we experience strong feelings of love or hate in an interaction there is an attempt to rationalise what is occurring. Conscious rationalisation invariably attributes the reaction to the social situation the overt relationship to anOther. Psychoanalysis's concept of transference exposes the unconscious source, purpose and potential of these powerful affects.

3.1.1 The libidinal drive, psychosexual development and repression

Transference has a direct connection to the libidinal drive relating it to psychosexual development and repression.

‘The essence of repression lies simply in turning something away, and keeping it at a distance, from the conscious’ (Freud, 1915c)p147.

Instincts have a constant force coming from within the subject, appearing as a need requiring satisfaction (Freud, 1915a)p122. Consequently instincts have a certain pressure, aim, object and source. The aim is always satisfaction, which may be reached by different paths. The Object is a thing through which the aim can be achieved, this may be internal or external to the subject and is the most fitting or readily available thing lending it an opportunistic quality rendering objects interchangeable. This flexibility, required for the satisfaction of an aim, in the identification of a suitable object allows the source to transfer from one object to another.

Freud divided instincts into two groups; ego or self-preservative instincts and sexual instincts (Freud, 1915a)p126. The subject of the mental health services, whose self-preservation instincts are challenged, will act opportunistically looking for satisfaction in the Other particularly as a part of the libidinal instincts remain associated with the ego-instincts through a subject's life span, which normally would go unnoticed but is clearly identifiable in the onset of illness (Freud, 1915a)p126. The onset of mental

illness provides a unique situation where the plasticity of the libidinal and ego instincts presents in an acute and more clearly observable manner.

The onset of illness does not dictate the loss of self-preservation instincts but creates a situation in which the aim of defence mechanisms alters. Instincts are therefore clearly adaptable and respond to the vicissitudes of life, in their need for satisfaction they adapt to the internal psychical world of the subject and the external social world. A number of defences such as repression, reversal into the opposite, turning around on the subject's own self and sublimation are implicated in this (Freud, 1914a)p94. Common to these defences is the linking back to their instinctual source the libidinal drive. The *Three Essays on Sexuality* (Freud, 1905c) demonstrate how the libidinal drive attaches itself to erogenous zones through which the external world is encountered and subsequently internalised. Initially Freud used transference to refer to the patient's reproductions of past relationships in the current relationship established with a neutral analyst (Dosamantes-Beaudry, 2007). Freud used the emergence of transference in sexual forms as evidence of the source of the driving forces of neurosis in sexual life (Freud, 1914-1916)p12. This libidinal development with its instinctual root in the id occurs parallel to biological progression and attaches social and relational experience to the unconscious elements of the developing ego. Primary relationships have an erotic quality maintain throughout the life span which are modified by the introduction of new knowledge (conscious and unconscious) and by subsequent libidinal relations alongside the vicissitudes of life.

3.1.2 The mechanism of transference

Transference does not just occur in the therapy relationship, it is ubiquitous occurring in a myriad of relationships with influential others. We expect others to respond to us as we have been treated before by our parents siblings and other significant people and we behave according to those expectations (Grant, 2003)p3. Demonstrating transference as implicated in interpersonal relationships requires a connection between consciously expressed expectations and unconscious desire. Health care delivery takes place within a subject-Other relationship which differs from a social relationship. It should aim to be a therapeutic professional relationship which places responsibility on staff to acknowledge and address subjectivity. Lacan supports the ubiquitous nature of transference on the basis that;

‘There must be, outside of the analytic situation, pre-existing possibilities which the analytic situation combines in what is perhaps a unique way’ (Lacan, 1994)p124.

We experience transference in immediate reactions of liking or disliking someone we have never before met, in the experience of falling in love at ‘first sight’ in our reaction to others. Love therefore is of interests to psychoanalysts because it allows us to ‘understand what happens in transference’ (Lacan, 1960-1961). The Other on to whom we transfer is often the subject supposed to know. This interest has resulted in the term transference being applied to virtually everything that transpires in the analytic setting (Fink, 2007)p128.

Fink (2007) describes a series of situations in which transference is experienced;

- At the *perceptual level*, where some sensory feature of the analyst reminds the analysand of a significant person from their past
- A *coded feature*, where something of the analyst’s environment reminds the analysand of a significant person from the past
- A *sign system*, which is a sub-heading for a coded feature and includes cultural and linguistic components
- An *expression of emotion or an affective effect*, the analysand detects in the analyst (Fink, 2007).

Transference operates both within and without a formal psychoanalytic setting but is not necessarily present in all interpersonal interactions. Fink’s (Fink, 2007) description cautions against attributing every action or reaction of the analysand as transference. Transference is an action of the unconscious, ‘the putting into operation of the unconscious’ (Lacan, 1994)p267. Conscious responses to events should not be misunderstood as transference, for example a patient may experience a strong feeling of anger towards a staff member who has failed to follow through on an agreed task; anger relating to the current social situation may be quite legitimate and not an example of transference.

The unconscious is economic in its activity and transference is not a chance disturbance it occurs repeatedly. Freud (1917) advocates that we recognise that we are managing a phenomenon which is enmeshed with the nature of the illness itself (Freud, 1917b)p442. What occurs is transference of feelings derived from somewhere else which are not justified by the situation yet the object has provided opportunity for their expression. Transference can present as a demand for love or in a desire to be loved, or it may be toned down to a suggestion for an on-going intense but non-sensual friendship (Freud, 1917b)p442.

Freud (1912) demonstrates that aims shift between objects and the libidinal instinct and are overwritten with socially prescribed norms, earlier stages of development and a recognition that only part of the drive that determine the course of the individuals erotic life may have negotiated all the stages of psychical development; the parts that have are directed towards reality and are open to consciousness;

‘Another portion of the libidinal impulses have been held up in the course of development, it has been kept away from the conscious personality and from reality, and has either been prevented from further expansion except in phantasy or has remained wholly in the unconscious so that it is unknown to the person’s consciousness’ (Freud, 1912)p100.

If an individual’s need for love has not been satisfied in reality the subject is going to approach every new encounter with unconscious libidinal anticipatory ideas creating an opportunistic love story that ‘exist only on the side of the patient’ (Lacan, 1960-1961)p5. Therefore I hold that anyone entering mental health care with a quantity of unsatisfied libido will direct it at those that express an interest in him and appear to desire him, giving transference a positive quality. This is upheld by the findings of this study, presented in chapter seven, which also indicate that many staff and patients experience a reversal into the opposite that is hostile or negative feelings (section 7.1).

‘It is very singular that love as the pure and simple power of unifying and of attraction without limits in order to oppose it to Thanatos; while we have correlatively and - as you can sense - in a discordant fashion, a very different and very much more fruitful notion in the love-hate ambivalence’ (Lacan, 1960-1961)p74.

3.1.3 The structuring effect of transference

Initial transference was considered a troublesome side effect of psychoanalysis to be overcome. Current understanding are considered to be central to understanding the analysand's process of transformation (Dosamantes-Beaudry, 2007). If transference was only a by-product of psychoanalysis it would be of little interest to anyone outside of that field.

‘Where no analyst is in view, there may be, properly speaking, transference effects that may be structured exactly like the gamut of transference phenomena in analysis’ (Lacan, 1994)p125.

Freud (Freud, 1912) held a similar position and was critical of non-analytic services, which enabled transference to emerge as a form of repetitive mental bondage as transference ‘is the automatism of repetition’ (Lacan, 1960-1961). Psychoanalysis utilises this natural phenomena while my thesis holds that mental health care ignores it; it misses the opportunity and is instead used by it. Psychoanalysis gives transference a structural quality that could be used to introduce the universality of its application (Lacan, 1994)p125. This is importance for anyone who engages in psychological work, in particular the mental health services. It requires staff to engage in the discourse of the Analyst in their relationships with patients. However I have suggested in chapters 1 and 2 that services primarily operate from Master and University discourses.

3.1.4 Differences in understanding transference

The Lacanian approach, understanding transference as a distortion, a dynamic position that evolves over time is addressed in Lacan's initial work on the topic ‘*Intervention on the Transference*’ (Mitchell, 1951); in which Lacan describes the transference in dialectical terms borrowed from Hegel and is critical of approaches that define transference in terms of affects. Transference may present as strong affects but that is not what it is, instead it is the structure of the relationship between subjects.

‘Transference does not refer to any mysterious property of affect, and even when it reveals itself under the appearance of emotion, it only acquires meaning by virtue of the dialectical movement in which it is produced’ (Lacan, 1993a)p225.

Both Klein (Klein, 1998) and Menzies Lyth (Menzies Lyth, 1988) made significant contributions to understanding transference. However they misattributed transference presenting as strong affects, which is, as Freud and Lacan noted, the structure of the relationship between subjects despite Freud's emphasis on a foundational patriarchal relationship occurring through the mediation of the Oedipus complex which underrates the strength of the maternal bond. Lacan persists in the belief that transference is structural throughout his subsequent writing and agrees with Freud connecting the manifestation of transference through desire. However in his conceptualisation of the subject-Other relationship he emphasises the formative role of the mother child dyad and adds to this by contending that desire is important but it is primarily a desire for knowledge. This manifestation of transference in desire and in particular in the love of knowledge allows Lacan to promote the idea that the analysand approaches the analyst as a subject supposed to know.

‘A man, the psychoanalyst, from whom one comes to seek the knowledge of what is most intimate to oneself and therefore of what should be supposed from the beginning to be the thing most foreign to him and moreover that one supposes at the same time to be most foreign to him is nevertheless supposed to have this knowledge’ (Lacan, 1960-1961).

The one on which we lavish our desire supposedly contains knowledge about our subjectivity that we do not possess, reflecting the early misplaced confidence the child has in the parent. This is visible in the relationships between service occupants (section 7.2.4). There is a set of relationships between the subject and others and between the others and the big Other founded on the principle of a subject supposed to know.

‘We bring into play a lot of things, a lot of functions of identification: identification to the one from whom we demand something in the appeal of love and, if this appeal is rejected, identification to the very one to whom we address ourselves as the object of our love and then, in a third sort of identification the object of the desire of the other to whom we identify ourselves. In short, our subjectivity is something we entirely construct in plurality, in the pluralism of these levels of identification which we will call the Ego-Ideal, the Ideal Ego, which we will also call the desiring Ego’ (Lacan, 1960-1961)p128.

3.1.5 Positive and negative transference

The initial template for the libidinal drive enables us to form later love relationships and ‘the transference is usually represented as an affect’ (Lacan, 1994)p123. Positive transference is normally identified with love whereas negative transference is never identified with hate instead we normally employ the term ambivalence. Lacan (1994) suggests that positive transference is when you have a soft spot for the subject and the negative transference is when you have to keep an eye on him (Lacan, 1994)p124. Keeping an eye on the patient, in particular patients that may harm themselves or others is a constant concern for staff whose practice is founded in observation and categorisation (section 7.1.5). Additionally patients observe and categorise staff for which they may have positive or negative feelings (section 7.1.2). However, even though we can equate transference love as true love, love is a deception (Harari, 2001)p96. Love is a deception because to love is the desire to be loved. Love arises from the libidinal drive, it is active but its aim is passive, its aim is not to love but be loved. Patients want to be loved by the staff and staff are overwhelmed by this (Menzies Lyth, 1989). This creates a problem for staff and the parts of society that base their endeavours in science, which is removed from the field of love.

‘Things that have to do with love are incommensurable with everything else; they are, as it were written on a special page on which no other writing is tolerated’ (Freud, 1915b)p160.

Analytic treatment cannot ignore desire it has to follow the libido and make it accessible to consciousness and in the end serviceable to reality. Psychiatric treatment tends to ignore or completely reject this reality, consequently establishing negative or hostile transference which in turn leads to acting-out (section 7.1.4).

3.1.6 Transference and acting-out

Transference acquires meaning through language but is connected to desire and knowledge, failure to find meaning leads to acting-out. Harari (Harari, 2001) argues that acting-out equals transference without analysis. Main (Main, 1957) identified that staff are required to respond to patients incidents of acting-out and are as prone to acting-out as those in care. In Main’s (Main, 1957) study the concern is with the reciprocal nature of unconscious fears and primitive fantasy that occur in mental

health units. He notes how critical incidents, evoke omnipotence and aggression in staff which is managed by the imposition of treatment.

‘Main described nurses who administered medication precisely at the moment when they could no longer tolerate the anxiety, impatience, guilt, hatred, and despair evoked by certain patients’ (Shur, 1994)p11.

Acting-out is the demand for love and the attempt to avoid anxiety. Lacan has clearly identified that if transference goes unanalysed, the analyst loses their position and the patient is effectively directed towards acting-out. What has not been heard or heard and not attended to by the analyst is returned in an action that can be observed (Harari, 2001).

‘Acting-out = transference without analysis
Transference = acting-out without analysis’ (Harari, 2001)p84.

Rowan (Rowan, 2000) argues that transference and acting-out are essentially manifestations of the same thing, that is repetition in the place of remembering. Rowan (2000), Harari (2001) and Freud (1914) highlight acting-out as communication which places a requirement on the Other to whom it is directed not to curtail it but to allow the patient to work through it, to overcome it, by continuing analytic work despite the acting-out. The exact opposite is more likely to occur in mental health services.

Acting-out has a greater power of demand than the symptom. Once a person is admitted to a mental health service the concern shifts from symptoms to the patient’s demands and incidents of acting-out. The subject is so overwhelmed by their anxiety that they take action; to demand is not the same as to ask for. The demand is for something else; it is a demand for a demand (Harari, 2001). If this demand is not met the Other is bypassed, the Other is no longer in the position of subject supposed to know and virtual transferences are demonstrated in the acting-out.

‘The savagery implied by this (virtual) transference that is acting-out without analysis asks the Other for symbolic restitution in a much more resonant manner than the symptom itself’ (Harari, 2001)p85.

Harari's signifier 'savagery' evokes a number of positions which are examples of virtual transference; Klein's (Klein, 1998) theory of infant object relations; Freud's (Freud, 1917b) notion of regression to primitive states; Menzies Lyth's (Menzies Lyth, 1989) commentary on defence mechanisms in nursing services and the savage attacks that patients commit on themselves in acts of self-harm. Acting-out is a defence against overwhelming anxiety and as in Main's (Main, 1957) case example, often met with a countertransference response from the staff leaving the patient overwhelmed and without an-Other towards which libidinal energy can be directed. The subject supposed to know becomes the subject who does not know as a direct consequence of staff failure to respond appropriately. Main (Main, 1957) noted that when nursing staff learnt how to better accept their negative feelings to patients who acted-out, the need to rely on medication to manage critical incidents dropped dramatically. He also identified that when new staff joined the team or at points of heightened strain there was a return to old practices of medication administration indicative of a process of regression.

These arguments establish transference as rooted in the libidinal drive, patients unconsciously relate to staff as the subjects supposed to know for satisfaction of desire. Staff operate from a discourse that fails to understand or work with desire, leaving the patient the option to demand, through acting-out, an affective response. Acting-out is generally seen as a negative behaviour and met with a countertransference negative reaction contributing to a hostile environment; this indicating that staff's transference to patients is a concern (sections 7.1.4 & 7.1.5).

3.1.7 Countertransference

Transference evokes responses in the Other described as countertransference. Freud and Breuer's *Studies in Hysteria* (Breuer, 1893b) demonstrates Breuer's strong bond with the patient (countertransference). Consequently he opted to terminate the treatment at a point when Anna O., appeared improved. However on the day he terminated treatment he was called to see the patient who was in a distressed state. Anna O. had expressed transference to Breuer and he responded with countertransference. None of the players was able to identify what was happening and consequently the transference and countertransference were mismanaged. In *The Psychotherapy of Hysteria* (Freud, 1893-1895) Freud attempts to explain transference,

noting the part played by the doctor in defeating resistance during treatment and proposing that friendliness operates as a substitute for love without which the treatment will fail.

This initial explanation attributes a nuisance quality to transference as it creates more psychological work, something else to be managed that appears to have no addition to the work and is a resistance that has to be overcome. However transference appears to follow a law and by 1905 Freud's position has shifted. In the case of Dora Freud acknowledged that it was his neglect of the transference that led to the early ending of her analysis (Dresser, 1985)p15. Neglecting transference leads to difficulties and breaks in the relationship between staff and patients. The staff, are unconsciously expected by patients to respond in a favourable manner. Freud expanded his conceptualisation of transference as an irritating side effect to the elevated position on which a cure could be achieved. This included acknowledgement that transference also operates in group situations.

Transference enables us to make and manage social bonds. Social bonds are dependent on the establishment of language, desire, laws and prohibitions which create groups and maintain social cohesion. The developmental cycle of infant to adult involves movement from total dependence on the (m)Other to independence, a shift from an exclusive bond to recognition of the alienated self as a desiring subject who can interact and work with others; a transformation from a unitary bond to the potential for multiple bonds is required. How transference is managed in the subject-Other relationship reflects the style of social bond utilised by the individual which in turn has implication about how the individual operated in the context of a group. In the context of nursing services the style of social bond has been under investigated.

‘Nursing takes place in the context of the nurse-patient relationship. Although there is a vast amount of nursing literature about this relationship, its psychodynamic aspects have remained largely unexplored. The concept of countertransference in the nurse-patient relationship has received little research attention but descriptions of this concept in clinical practice have been given’ (O’Kelly, 1998)p396.

Services are designed and structured to facilitate groups; therefore, the shift from individual to group psychology is a concern.

3.2 Group Psychology

Utilising psychoanalysis to explore unconscious aspects of a social group differs to how the work is conducted with an individual client. Patterns of relationships (inter-subjectivity) alongside individual perceptions require exploration; understanding of the function of transference in group psychology is required. Donne's 'No Man Is an Island' (Donne, 1624) is suggestive of an externally imposed inevitability. The mental health service is structured to deliver care to defined geographic populations, the patient's address dictates treatment from a named team, structured around a legislatively legitimised leader; service occupants are required to operate in specific designated social groups. There is inevitability for the patient which forces a particular identification, their experience, like Donne's, is dominated by sickness. Being dominated by mental ill health creates a particular vulnerability. In the association between the self-preservation and libidinal instincts and the plasticity of object choice, which allows for the unconscious choosing of an object as an ego ideal, who may be very distant from the ideal chosen should the person be in a state of health; the choice of ego ideal is limited as the leader for the social group is prescribed by the HSE structure. Freud's (Freud, 1921a) *Group Psychology* demonstrates how the subject-Other relationship adapts. De Board (DeBoard, 2005) argues that Freud's (1921) *Group Psychology and the Analysis of the Ego* shows how psychoanalytic thought has always been concerned with social psychology.

3.2.1 Transition between individual and group psychology

Individual psychology is rarely in a position to disregard the relationships that each individual has with others. Individual psychology is 'at the same time social psychology' (Freud, 1921a)p69. Freud (Freud, 1921a) and Bion (Bion, 1990) argue that groups are bound together by emotional ties, expressions of desire towards the leader, who holds the position of the Other. This emotional tie is the result of identification, where group members interject what they admire in the leader into themselves and develop an internal object, an ego ideal. Group members become bound to each other through identification as they share an ego ideal. The leader, elevated to ego ideal exercises power over the group. Three factors combine to bring about this process;

1. Identification
2. Leadership
3. Ego ideal

Both Bion (Bion, 1990) and Freud (Freud, 1921a) differ from earlier theorists who favoured the notion of a group mind or herd instinct; on the basis that numbers alone are not significant enough to evoke an instinct that otherwise would not be called into play. This is additionally supported by Menzies Lyth (1988, 1989) who identifies group functioning not as a derivative of some primitive group instinct but originating from the smaller unit of the family. The theorists agree that through identification individuals behave differently in individual and group situations (Freud, 1921a, Bion, 1990, Menzies Lyth, 1988, Menzies Lyth, 1989, DeBoard, 2005).

3.2.2 Pressure to conformity, power, contagion and suggestibility

Group functioning is aided by power and contagion but not exclusively as doubtlessly something exists in us which, tends to make us fall into the same emotion expressed by others even though we also have the ability to resist the emotion and react in an opposing manner (Freud, 1921a). Lacan cited in Leader (Leader, 1995) notes the element of contagion that occurs in the infant's mind as a primitive stage of development where the young child has not differentiated himself from the other. This is observable in the contagious elements of emotional responses in groups of toddlers and understood as identification with an external object (Leader, 1995). Identification with a specular image is part of the organising principles of childhood allowing the child to recognise they can do things they were unable to before. This has a positive effect enabling the toddler to experiment with his abilities and learn new skills. However, by adulthood the ability to successfully oppose this has developed. The regression that occurs when faced by anxiety is partially contained by identification with another, allowing the individual to believe they can operate in the same manner as another group member. Linking contagion to regression supports Freud's (Freud, 1921a) position that groups are drawn to the response of the lowest common denominator and Menzies Lyth's (Menzies Lyth, 1989) argument that being part of a social group involves regression to primitive states supported by service structures and protocol.

‘When a man becomes part of an organised group he descends several rungs in the ladder of civilisation. Isolated he may be a cultured individual; in a crowd, he is a barbarian - that is a creature acting by instinct’ (Freud, 1921a)p77.

The acting on instinct and a latter comparison of the influence of the group with the mental life of primitive people supports the position that regression occurs due to the influence of the group. Consequently there is a shift to the lowest common denominator and the obstruction of intellectual endeavours because an intensification of affect in the group creates conditions unfavourable to productive intellectual work. Individuals are intimidated by group power, their mental activity is inhibited and this results in a lowering of personal responsibility (Freud, 1921a).

Groups can have a powerful positive or negative effect on the ethics of the individual. Freud argues that a group is ‘impulsive changeable and irritable’ (Freud, 1921a)p77, and group feelings are always ‘very simple and very exaggerated’ (Freud, 1921a)p78. Lowering of the intellectual capacity to a common denominator is supported by acknowledging that the intellectual ability of the group will inevitably be significantly lower than that of the individual. The influence of the group ensures that its ethical conduct may rise high above the individual’s or sink deep below it, (Freud, 1921a)p79. A reduced intellectual ability alongside exaggeration of simple feelings allows contradictory ideas to coexist and tolerate each other without any conflict arising from the logical contradiction, supporting Freud’s argument that groups have a capacity to contain and operate with paradox in the same fashion as the unconscious.

3.2.3 Love, hate and group identity

Transference is linked to group behaviour by Bion (Bion, 1990) particularly in the concept of pairing. Groups behave as if their existence depends on two members pairing off and creating a new leader a hoped for essentially sexual act of creation of a messiah. Transformation between the unconscious and the conscious and the diversion of aim appears in the services as hope for a new treatment or service structure; a hope that exists as long as the basic assumption of pairing is a defence mechanism of the group enabling the group, to reject reality and retain the closed system sustained by illusion, an operation in the imaginary register.

Enduring intimate relationships contain elements of both love and aversion (Freud, 1921a). The same ambivalence is notable in groups in the coexistence of an unmistakable readiness to love and hate the Other concurrently. Freud (Freud, 1920) describes this as opposition between the life and death instincts, a tension between narcissism and altruism. To fit in a group there is a need to relinquish an element of narcissism demonstrable in the developing child's relinquishing narcissistic elements to join the social world.

‘Love for oneself knows only one barrier love for others, and love for objects’ (Freud, 1921a)p102.

In groups, workers form ties which go beyond the function of the group. The libidinal drive is diverted from its original sexual aim and the emotional ties that bind groups together are represented by identifications between members and with a shared ego ideal. This is observable in the altruistic act of caring between patients and staff (sections 7.1.2 & 7.1.5). The reversal into the opposite also holds; true love transforms into hate and acts of egotism and blatant disregard for others. A failure of altruism is equally observable in services, particularly where there is a tension between groups and the only available leader to identify with has been imposed upon rather than chosen (section 7.3.2)

3.2.4 Identification

Identification has been acknowledged as the initial emotional bond that is formed with another. In a group context it follows two paths; with the leader (ego ideal) and with others who share the leader (ideal ego). It is ambivalent ‘it can turn into an expression of tenderness as easily as into a wish for someone's removal’ (Freud, 1921a)p105. This ambivalence allows for the coexistence of conflicting emotions. The object that is desired is assimilated into the unconscious by devouring it and in this way destroying it. The cannibal remains at this primitive stage of development;

‘He has a devouring affection for his enemies and only devours people of whom he is fond’ (Freud, 1921a) #80}p105.

Cannibalistic consuming affection suggests that the initial libidinal bond is comprised of two opposite powerful emotional responses activated by anxiety, which if they

remained in adult life as the only method of forming identifications, it would be impossible to form complex relationships. The child's world is smaller and is dominated by a few objects. This provides intense experiences 'that can completely flood the child's emotions' (DeBoard, 2005)p25. The adult world is inhabited by numerous people connected through complex networks of social relationships. Volume, psychical development and engagement in a social group influences identification configurations, there are more people to form identifications with and the adult with a super ego in place, has negotiated physical and psychical developments that have moderated patterns of identification. The rules for the process of identification culminate in the mediation of the Oedipus complex.

3.2.5 The Oedipus complex

Freud's (Freud, 1921a) conceptualisation of group psychology demonstrates how the subject-Other relationship adapts from individual to group psychology and is based on the model he developed around the infant's shift from an exclusive bond with the (m)Other to integration into the larger social group of the family. This integration happens in conjunction with the development of language. Transference plays a significant part in this development enabling the individual to engage with others who provide an opportunity for the unconscious displacement of feelings, drives, attitudes and defences which are a 'repetition of reactions originating in regard to significant persons of early childhood' (Greenson, 1967)p155. The Oedipus complex is synonymous with the shift for the developing child from an exclusive dyad bond to the development of serial additional social bonds, inclusive of a stepping away from narcissism and engagement in a group. The original relationship and mediation of the Oedipus complex broadens and moderates the template for the individual's style of formation of social bonds.

Freud (Freud, 1905c) describes a triangular relationship between child, mother and father; the organising body of loving and hostile wishes that influence the identification during the phallic stage of development. It is marked by biological reality and the introduction of law, the prohibition of incest, and has a structuring effect on the psyche and desire of the individual. Following mediation of the Oedipus complex and the formation of the super ego, the child's world expands beyond

primary relationships, reflective of the bourgeois family unit replicated by Tuke in the structure of the asylum.

Lacan (Lacan, 1993a)p22 notes the evolutionary quality of physical and psychical development and takes a dual approach on identification considering it from imaginary and symbolic perspectives. Imaginary identification occurs during the mirror stage of development when the child identifies with the image of itself. The ego is created by identification with an external object which acts as a rival to the self therefore it involves both aggression and alienation. This contributes to creating an ideal ego (identification with others) as distinct from an ego ideal (identification with the Big Other). The ego ideal is as a result of identification with the name of the father during the Oedipus complex, a secondary identification brought about by the transition of the subject into the symbolic order. Lacan favours a structural element not as apparent in Freud. Central to this structural element is the imposition of law and the containment of knowledge in an external source, it comes from (an)Other but not any other a Big Other, the subject supposed to know.

Identification contributes to ego formation after the style of the one that is taken as a model. Freud and Lacan agree that identification is fundamental in the formation of the individual and this early stage of development creates a template that even when modified by exposure to a larger more complicated world of subject-Other relationships, influences the formation of social bonds.

‘The further the subject directs his aim, the more he is entitled to love himself - in his Ideal Ego as we would say - the more he desires, the more he himself becomes desirable’ (Lacan, 1960-1961)p112.

Group members require the leader to have a common quality or set of qualities they can relate to. Transference relationships ensure that the Other is the one who appears to know something about the subject that they may share therefore they are an object of anxiety. This is observable in the services when the doctor or his agent casts his gaze on the patient and categorises with the aid of his Master discourse, embodied in the DSMIV (American Psychiatric Association, 1994), giving him a knowledge about the patient’s symptoms that they do not possess themselves (sections 7.2.1, 7.2.4 &

7.3.2). However this general knowledge is not necessarily true for the subject, a reality that the group willingly tolerates for survival.

3.2.6 Illusion, truth and reality

Groups have a total disregard for the truth, sacrificing truth to maintain survival. The imaginary realm draws us into alienation from the truth about the self, groups are not interested in the truth, they demand illusions and cannot operate without them, 'giving the unreal precedence over the real' (Freud, 1921a)p80. Individuals protect themselves from the truth by symptoms; groups shelter themselves in myths and legends. Sacrificing the truth for illusion has implications for the work of the group as energy is diverted from its stated task into maintaining illusion. Providing care for patients who have little hope of improvement or recovery is well documented as unpopular and difficult, often resulting in the adoption of illusions, unrealistic expectations or paternal attitudes. Miller and Gwynne (Miller, 1972) found staff liable to develop defences against the reality of work, prolonging life at all costs, adopting denial of patients' abnormalities and fostering unrealistic beliefs about normality. This encourages the development of rehabilitation and recovery styles of therapy so that a return to the world outside the service can be considered, despite its often apparent unreality. Frequently patients receiving this type of care are subjected to being dehumanized or at the least treated like minors.

A number of researchers, (Miller, 1972, DeBoard, 2005, Menzies Lyth, 1988, Menzies Lyth, 1989, Freud, 1915b), found a process of scapegoating of staff and patients, in which staff are viewed as central to the problems of the service and sadistic in their approach to others. Patients viewed in similar terms were subjected to dismissal and attempts to have them transferred (sections 7.1.2, 7.1.4 & 7.1.5). Staff can be understood as simultaneously operating both as an idealised and sadistic parent (Klein, 1952).

Groups adopting dehumanising and sadistic approaches are distant from reality and without any standards or ethic. Bion's (Bion, 1990) concept of the basic assumption group recognises and supports the disregard for the truth in the unconscious life of the group being reflected in its day to day behaviour. In a basic assumption group, the group behave in a particular mode as if all the members hold a common basic

assumption. McDougall (Freud, 1921a) previously identified that for a group to form there needed to be a common interest in an object. Bion (Bion, 1990) basic assumption groups' common interest is the group leader. If operating in illusionary and basic assumption mode is the totality of the service group's capability their interest will remain focused on the own survival and the patient as subject will not be addressed.

‘At an organisational level, it has been observed that those who work within the context of a harmonious ideological community (e.g. a religious community) are less vulnerable to burnout Freud and other researchers on mass-psychology have observed that primary masses (such as care-giving institutions) can achieve edifying results’ (Vanheule, 2003)p38,

Achievement of edifying results is dependent on the quality of the ego ideal as a shared object for the group (Freud, 1921a, Menzies Lyth, 1989, Bion, 1990, Vanheule, 2003). In unedifying groups the Big Other/ego ideal either lacks the qualities that allow the group to create a harmonious ideological community or there may be an issue of exaggerated expectations (Vanheule, 2003, Kanter, 2007).

‘Several studies indicate that burnt-out professionals once started their job with idealism and exaggerated expectations. These expectations concern, on the one hand, the organisation and, on the other hand, the idea that as caregivers they would be able to have a substantial influence on negative situations. The moment it becomes clear that such expectations are based on illusions, the consequence seems to be burnout’ (Vanheule, 2003)p38.

Group functioning requires members to cooperate on a task, individuals work for themselves within organisations unless the pressure of the group task moves them in another direction (Bion, 1990, DeBoard, 2005). The shared ego ideal and shared task help the group move from basic assumption to working mode. Working groups grow and develop and are in touch with reality, operating as an open system realising that work has to be done to maintain the balance of forces between what is within and what is outside the group. As a working group the mental health services recognise what is required to provide a good enough culturally appropriate service for patients, working groups such as the Expert Group on Mental Health (Expert Group on Mental Health Policy, 2006) are attempts by services to grow and develop.

The basic assumption group is primitive and id like, it remains in stagnation and regression, a closed system that ignores external reality and defends itself from it. The working group is similar to the concept of ego mediating between external reality and the self. Services display aspects of a basic assumption group, there is a proliferation of leaders, the rejection of external reality, the adoption of parental attitudes and unrealistic expectations, the maintenance of an unyielding bureaucracy and a defence system against anxiety (Bion, 1990, Miller, 1972, Freud, 1921a, Menzies Lyth, 1988). In this context working groups such as the Expert Group on Mental Health (Expert Group on Mental Health Policy, 2006), are severely hampered as their productions can be ignored or dismissed unless the basic assumption group can be openly challenged, deconstructed and redeveloped (Fotaki, 2010).

3.2.7 Ethical standards in groups

Fully functioning groups involve psychical shifts from primitive id states aimed at survival and jouissance to ego states subject to influences from a superego created through identification with an ethical Big Other. Individuals generally fail to meet societal ethical standards, in services the combined proliferation of leaders, rejection of external reality, maintenance of bureaucracy and impossible act of caring constantly fragments group cohesion (sections 7.4.2, 7.4.4 & 7.4.6). It is as if societal standards are aspirational and beyond the individual's ability. However, Vanheule (Vanheule, 2003) notes that identification with an ego ideal can have a profoundly positive effect. In relation to intellectual work Freud argues that;

‘Great decisions and momentous discoveries are the realm of the individual but groups are capable of creative genius in the field of intelligence, as is shown above all by language itself’ (Freud, 1920)p83.

Groups can take ethical stances, set higher standards than the individual, requiring member's to act truthfully and ethically by fostering appropriate standards and social bonds.

Standards are troublesome and a number of authors (Vanheule, 2003, Moyle, 2003, Kanter, 2007, Fotaki, 2010) express concern about health services restructuring around standardised notions of care which increase bureaucracy and distance staff

from patients. Technical aspects of care become the focus at the expense of the subject-Other relationship.

‘We can also argue that our culture is increasingly orientated towards controlling our environment (e.g. science and technology). ...within this cultural context of omnipotence, the uncontrollable subjective dimension is increasingly difficult to bear. In this context we advise that concepts such as efficiency and efficacy, which enter into care-giving via quality-management, be dealt with cautiously. Aspiring after efficacy implies a belief in the verifiable nature of care-giving. In the context of interpersonal professions, however, the radical non-verifiable dimension of interventions is a major issue one can’t just neglect’ (Vanheule, 2003)p39.

Efficiency and efficacy, signifiers of measurement, capture aspects of care while failing to acknowledge transference management as an element of care giving. Language, the product of the group, the medium for creating social bonds and expressing desire, is implicated in truth. However, the language we speak comes from the Other and fails in the gap between articulation and experience.

In language the truth can be discovered ‘the articulation of the truth is central in psychoanalysis, the articulation of desire’ (Lacan, 1993a)p144. Analysis provides a construction of the truth of the subject, truth is essential for understanding madness;

‘Modern science renders madness meaningless by ignoring the concept of truth’ (Lacan, 1993a)p153-4.

The illusion of the leader as subject supposed to know is sustained by the language of the organisation giving his declarations a gloss of truth supported by social bonds.

3.2.8 Groups and leaders

Groups organise themselves around a leader (Freud, 1921a, Bion, 1990, Lacan, 1994, DeBoard, 2005, Freud, 1913-14). Freud (Freud, 1913-14) emphasises the significance of the leader, arguing that the early organisation of society resulted from males in the group cooperating in killing and consuming the father in order to possess his power and gain access to the females. The leader has to be annihilated for the group to function, the act of killing and consuming the leader creates a social bond and the emergence of rules and prohibitions, ‘a struggle for power and a possibility for self-

realisation' (Vanheule, 2003) are linked by this mythical action. This allows members to elevate the dead leader and create an ideal, imposing external power under which the group can be organised; the act of consuming gives the ideal an internal quality. Lacan, shift in emphasis from an actual father/leader to the name of the father/leader as representing prohibitions allows me to argue that a group is founded on laws.

This requirement for leaders empowered by laws is observable in services at clinical and administration levels (sections 7.2.1 & 7.4.1). Nursing services have nine grades of staff, medical services have fewer subdivisions, other health care professionals organise themselves around junior and senior posts, administration is provided by a range of officers denoted by grades. Each group's subdivision has rules and prohibitions about authority creating services populated by a profusion of leaders; everyone shares a bit(e) of the power of being a leader. Across all professions higher grades spend less time in contact with patients, sustaining group illusions and benefiting from the jouissance produced by the work of lower grades and patients. A proliferation of grades enables the formation of numerous subgroups, promotes bureaucracy and the dilution of truth. Bion (Bion, 1990) noted that for a working group to function there is a requirement to create subgroups that manage identified tasks. A perfusion of leaders across diverse professional groups fragments notions of a unitary ego ideal. This makes identification problematic. It inhibits services operating as a harmonious ideological community capable of great decisions and momentous discoveries. The concept of an ideal of services and attempts to contain the perfusion that exists, is provided by recourse to external sources for rules and prohibitions, primarily the discourse of the law, the *Mental Health Act* (Government of Ireland, 2001a) which attempts to reunite services subgroups by identifying the Consultant as leader around which the group can form.

The dependency group is sustained by a leader. Members depend on the leader for maternal and spiritual nourishment and protection; being sustained takes precedence over any group purpose. The group members behave inadequately or immaturely, as if they knowing nothing and having nothing to contribute (Bion, 1990). The leader is omnipotent and omniscient, someone who can solve all difficulties and problems magically. This has a powerful effect on the leader as sooner or later they arouse

group disappointment and hostility. When this happens the group rejects the leader and appoints another one, usually the sickest member. This is followed by demoting the new leader and attempts to reinstate the former. The leader is alternatively good or bad and an explosive situation occurs that is not always contained, the group can easily subdivide. A dependency group creates particular problems in an organisational context where there is a statutory enforced leader. Every time he fails and is unconsciously demoted by the group a power struggle between the appointed and the chosen leader commences.

3.2.9 Power of affects

Theorists as early as McDougal (Freud, 1921a) suggested that groups are unruly and prone to strong affects that influence decisions and evade intellectual discourse. Consequently groups manage by reserving intellectual tasks for individual members, creating a struggle if there is desire to raise collective power to a higher level. Continuity is provided by retaining the same members for extended periods of time or the development of fixed positions, without which the group is constantly subject to the anxiety of new members (Freud, 1921a, Main, 1957, Bion, 1990, Menzies Lyth, 1988). The individual must develop some defined idea on the natural functions and capacity of the group to have an emotional tie to it. The group must be brought into interaction with similar groups even if it is in the form of rivalry (section 7.1.7). This is achieved in health care by similar services, sharing ideas, comparing outcomes via research studies, annual reports, national standards and targets.

Additionally, groups possess traditions, customs and habits, reflecting relationships between group members to give the group a defined structure expressed in its specialisation, mental health care; a differentiation from other health specialities. Menzies Lyth (Menzies Lyth, 1988) notes that intellectual work is taken away from members and individuals are assigned tasks therefore avoiding thinking about the work as a defence for the individual. Menzies Lyth's (Menzies Lyth, 1988) was influenced by Jacque's (1951) study, which tested the hypothesis that a primary force causing the cohesion of people in organisations is their defence against anxiety, with the converse that organisations are used by individuals as defence mechanisms against their own anxiety. Menzies Lyth (Menzies Lyth, 1988) took the presenting problem as a socially acceptable way of expressing the manifestation of unconscious issues un-

coverable through analysis, concluding that a factor determining an organisations structure, culture and mode of operation, is its social defence system. Collusion occurs between members of the organisation as they attempt to operate their own psychical mechanisms, other researchers support this perspective (Freud, 1921a, Main, 1957, Sherif, 1972, Bion, 1990, DeBoard, 2005). Additionally Menzies Lyth (Menzies Lyth, 1989) suggested that the system of defence developed to protect individual needs became fixed and rigid in nature operating as repetition.

3.2.10 Repetition

Staff under the influence of group power succumb to repetition, consequently new staff are forced to accept the hospital norms and are unable to instil change (Menzies Lyth, 1988). This protects the group from exploring alternative ways of working. Dependence on repetition fulfils the task of keeping intellectual work at bay, transferring it to the leader. If the leader engages in intellectual work, suggesting changes for the group, the primitive mechanisms the group revert to will ensure the utilisation of repetition to defend the status quo. This is occasionally achieved by placing sanctions on group members who question the system.

Freud, (Freud, 1921a)p93 demonstrated the severe sanctions for individual who attempt to leave a group that they did not freely choose to join. In Mental Health Services patients can be compelled to attend through involuntary detention or coercion by staff whose choices about work practices are also dictated by external forces, professional and statutory organisations,⁸ often described by staff as benign or punishing.

The church, army, and mental health services have identifiable leaders all with the essential illusion that leaders ‘love all the individual members in the group with an equal love’ (Freud, 1921a)p94. Libidinal ties that attach individuals in two directions to a relationship with others and the Other, this stabilise his position in the group. The ties also lead to ‘the alteration and limitation which has been observed in him’ (Freud, 1921a)p95. The strength of a libidinal tie is observable in how groups occasionally display panic. In panic situations the leader’s orders are ignored; individuals act for

⁸ An Bord Altranis, Psychological Society of Ireland, Medical Council, HSE, Department of Health, the Law, etc.

themselves without concerns for the rest of the group; the libidinal ties cease and overwhelming fear exists. The individual's panic does not necessarily equate to the level of danger to which they are exposed. Fear in an individual is provoked by the greatness of the danger or the cessation of libidinal ties. Organisations protect themselves against the emergence of panic by creating a task orientated system, (Menzies Lyth, 1988).

Groups are susceptible to panic at the loss of the leader and leaders guard against it by putting in place others to lead in their absence, a system described in the services as 'acting-up'⁹ which sounds similar to 'acting-out'. Panic places the group and its leader in a fight/flight mode (Bion, 1990) as if the group has met to fight something or to run from it. This group ignores or suppresses all other activities, the leader gains an elevated status and must lead the group against the enemy or create one, making him a creature of the group with no freedom to be himself. In services the on-going perception that patients pose a physical danger to staff is an externalisation of the unconscious anxiety arising from their demand, which ensures that staff frequently operate from a fight/flight mode (section 7.3.4).

Groups disregard reality and operate within systems that maintain and support their illusions. The church excommunicates members who oppose theology; mental health services exclude diagnostic groups. For example addiction and personality disorder are included in the categorisation system of the DSMIV but recommendations in the *Vision for Change* (Expert Group on Mental Health Policy, 2006) are that these groups should be treated in as far as possible outside the system. Individuals with these diagnoses are undesirable as they demand something from staff (section 7.4.4). The libidinal tie that may exist with other patient groups suffers reversal into the opposite when patients with these diagnosis enter services and is displayed in hostility hate and aggression between patients and staff (Freud, 1921a, Main, 1957, Menzies Lyth, 1988, Miller, 1972). Utilising powerful libidinal ties enables inclusion or exclusion of others on any pretext, religion, race, and mental state or scientific opinion.

⁹ Term used to describe a subordinate taking a superiors management/leadership responsibility

The emergence of the DSMIV (American Psychiatric Association, 1994) is an example par excellence of the power of a group to exclude at the level of illusion and disregard reality while protecting group integrity (PDM Task Force, 2006). The illusion is supported by the creation of new and more extensive additions of the DSM to cover up or exclude gaps. The DSMIV, conceiving mental disorders longitudinally rather than at a given moment, enables psychiatry to keep pace with medical trends towards evidence based practice, focusing on diagnosis rather than the patient story and history (section 7.3.2). Holmes and Warelw (Holmes, 1999) argue that the DSMIV, in which illness is a socially constructed category, and biological phenomena are treated as pathological to create evidence for disease, illness and disorder, has the potential to exercise social control over everyone. This credits significant power to the subject supposed to know in receipt of the group's libidinal energy to impose diagnosis and/or treatment that an alternative discourse would not consider.

3.3 Conclusion

Transference is the ubiquitous, opportunistic manifestation of the libidinal drive that colours subject-Other relationships. It has a particular relevance in mental health care where engagement involves identification of an ego ideal and development of an ideal ego. Anxiety, fundamental to the human condition, colours these identifications particularly when the additional anxiety associated with a mental health issue emerges. The emergence of mental illness and the associated socially endorsed and constructed treatment places the individual in a group dominated by a subject supposed to know. Illness threatens self-preservation increasing anxiety and the opportunistic manifestation of transference. The regression associated with admission makes patients vulnerable to transferring powerful affects onto staff.

The Master and University discourses dominate mental health services with a prevailing scientific discourse disavowing the truth of the subject. Staff operate within a general knowledge and are overwhelmed by the patients demands. They misunderstand or fail to acknowledge transference. Unacknowledged and unanalysed transference resulting in acting-out and this leads to repeated incidents of misattribution. This is overwhelming for patients and staff and conducive to utilising defence mechanisms as protection from libidinal energy, consequently love is converted to hate, care to carelessness and comfort to aggression.

This contrasts acutely with the discourse of the analyst where transference is managed and is the primary process through which the subject comes to recognise the truth about the self and through which analysis progresses. Ignoring and/or dismissing the centrality of transference service providers create an environment where two conditions prevail; a hostile negative transference and poverty in symbolic engagement resulting in aggressivity and acting-out. Subsequently services maintain a status quo of a surplus of symptoms in patients and staff, a constantly threatening environment where all parties experience fear of fragmentation and overwhelming anxiety.

The overwhelming impossibility of caring, managing the libidinal energy is addressed by recourse to a system built around an illusion that subjects can be observed, categorised and treated via a manualised nosology the DSMIV. Mental health services operate in a legitimised societal structure lead by a Big Other requiring the individual to relinquish part of themselves to survive, they conform to the unconscious rules of group behaviour, identification with a shared ego ideal who loves all members equally and willingly sustains them, creating tension between members for the affection of the leader.

Chapter four concentrates on transference management to support the claim that the discourse of the analyst enables the subject to recognise the truth about the self. The function of transference enactment in patient care in the particular practice of mental health is explored with emphasis on essential elements of service provision and their relation to transference.

Chapter 4 Working with and through Transference

This chapter expands concepts introduced in chapter two and three with an emphasis on working with and through transference. Particular reference is made to transference in the mental health service with an emphasis on service provision and its relation to transference in the context of, resistance, repetition and repression, truth and illusion, narcissism, knowledge, relationships, reality and change. Lacan (Lacan, 1994) argues that the concept of transference is determined by the function it has in a particular practice and visa-versa.

‘This concept directs the way in which patients are treated. Conversely the way in which people are treated governs the concept’ (Lacan, 1994)p124.

Freud (Freud, 1912) holds that a service which does not recognise and work with the unconscious generates negative and hostile transference.

4.1 The emergence of transference

Transference in a health care context appears as one of two possible contrary conditions, love or hate, at a time when the patient cannot articulate their problem; it is at a point where there is a failure in the ability to symbolically represent the root of the illness, the patient’s way of diverting from something in the unconscious.

‘As an affectionate trend it has become so powerful, and betrays signs of its origin in a sexual need so clearly, that it is inevitably provokes an internal opposition to itself’ (Freud, 1917b)p443.

If the transference consists of hostile instead of affectionate impulses;

‘The hostile feelings make their appearance as a rule later than the affectionate ones and behind them; their simultaneous presence gives a good picture of the emotional ambivalence which is dominant in the majority of our intimate relation with other people’ (Freud, 1917b)p443.

Transference emerges around something that is repressed and the patient will resist the exposure of the repressed.

4.2 Transference and resistance

Resistance occurs when the patient transfers onto staff intense feelings which are greater than the experience the therapy can justify. This is a critical point in treatment, and it is important that staff recognises and manages what is happening. On resistance Fink (Fink, 2007) cautions the analyst to be careful about what he is naming as transference and what resistance may be attributed to other factors in the analytic process. Firstly Fink (Fink, 2007) cautions against ‘affect hunting’, constantly asking the analysand how they feel, as although transference may be expressed as a feeling, it is an unconscious idea. Affect hunting is a common strategy in humanistic psychotherapy the approach identified as a philosophical underpinning of mental health services, (Expert Group on Mental Health Policy, 2006). What might appear as resistance, intractable silence, lack of free association, difficulties in remembering, missed and cancelled appointments may be part of other difficulties associated with treatment. Treatment difficulties generally arise from;

‘The fact that it is not easy to articulate what has never before been articulated, from the repetition of an earlier situation, which may be very complex and hard to elucidate, from something the analyst is or is not doing, for example refusing to help the analysand articulate what has never before been articulated’ (Fink, 2007)p132.

4.2.1 Resistance and therapeutic alliance

There is always resistance to the removal of repression overcome in the initial stages of the subject–Other relationship by interpreting, discovering and communicating with the patient. The patient works with staff to achieve this and central to the success of this initial work is the patient’s desire for recovery alongside his intellectual ability. In order for this initial work to happen a bond between the patient and staff, a therapeutic alliance is required. Therapeutic bonds are formed by the same process that creates social bonds. However, a social bond will not sustain a therapeutic relationship.

Therapeutic alliance develops when both parties willingly work together to achieve a common goal. Casual observations of staff-patient relationships can identify therapeutic alliance when it occurs. The patient expresses interest and faith in the staff and begins to rely on them as a source of knowledge and recovery. This interest

begins to extend beyond the patient's interest in their symptoms and may express itself as a special interest in the staff. The patient becomes more compliant and makes expressions of gratitude and praise; it is a rewarding experience for staff and expresses itself in their enjoyment of the work and often the expression of favourable comments about the patient.

Freud (1917) expounds a system of analysis that enables the patient to reach a point '...where there is nothing we would rather bring about than that the patient should make a decision for himself' (Freud, 1917b)p433. With young, helpless or unstable patients it is not always possible to achieve this within the work of analysis, requiring the analysis to combine the role of analyst with that of another member of the multidisciplinary team who will also provide caring and education functions, both provided by the services. Freud is not adverse to this role, provided it is done with consciousness of responsibility and undertaken with appropriate caution. Freud recognised attachment by the patient to the analyst and remarked;

'In the early years of my psychoanalytic practice I used to have the greatest difficulty in prevailing my patients to continue their analysis. This difficulty has long since been shifted, and I now have to take the greatest pains to induce them to give up' (Freud, 1913b)p130.

4.2.2 Resistance of the patient

Excessive valuing or devaluing of subject-Other staff-patient relationship can cause engagement/disengagement in treatment. Nobus (2002) relates this to 'the vicissitudes of transference' (Nobus, 2002)p106 as it has an effect that causes the patient to leave treatment prematurely or to remain in treatment beyond a therapeutic time period. Freud (Freud, 1905a) attributes resistance to transference as a cause of the premature termination of treatment. Nobus (Nobus, 2002) states that Freud's early commentary on transference allow the initial conclusion that;

'It's manifestation can lead to the analysis becoming either unperusable or interminable' (Nobus, 2002)p108.

Freud's early mismanagement of transference resulted from misunderstanding, consequently, it resulted in a negative reaction on the part of patients; failure by staff

to work in an informed manner with transference has a similar effect. Patients develop excessive dependence on or abhorrence for staff, shifting the patient from a concern about their symptoms to a concern about the staff. Staff's countertransference creates a concern about the patient and shift from the patient's symptoms to concerns about them as a good or bad subject. The positive experience by both in the alliance is not an on-going part of an analysis. Patients resist analysis and reach a point where they state that they have nothing more to say and no longer comply with the instruction to free associate.

4.2.3 Resistance of the staff

Therapeutic alliance, the essential first step in forming a relationship, arises from the patient entering therapy with the wish to seek leaders who have some hold over them, who operate from a master discourse (Freud, 1921a, Lacan, 1994).

‘The analysand comes into analysis asking to be ordered, or at least, wanting the analyst to wield a curative power over him/her’ (Moncayno, 2008)p157.

This gives staff a licence to mismanage therapeutic alliance by addressing the ego and not the subject, offering only containment and control to patients.

‘Lacan always insisted upon differentiating psychoanalysis from the direction of souls or pastoral or any other variety of counselling. Subjected to the demand of the Other, the neurotic can tolerate being in a situation where he/she may have to speak with his or her own words rather than with those of the Other’ (Moncayno, 2008)p157.

Desiring to be directed by the Other the analysand and analyst commence with an ego to ego relationship based on conscious communication, this is achieved by service staff and other forms of psychotherapy. The ego of the patient claims not to know the cause of their symptom, placing the staff in the position of subject supposed to know, who as well as providing an answer is empathetic in approach, a claim that allows the patient to maintain their symptom.

‘If the analyst believes in the symptom, in the conscious story line or narrative or in the transference to the subject supposed to know, then the analyst will collude with the resistance of the analysand. This is what Lacan calls resistance, the resistance of the analyst. Lacan believed that ‘there is no other resistance to analysis than that of the analyst himself’ (Fink, 2007)p132 citing Lacan (Lacan, 1997).

Treatment difficulties often result from staff obstructing the process or refusing to see what is happening. This resistance on the part of staff is found in services, as staff are seduced by the symptom, the patient's narrative and transference to the subject supposed to know, however intense feelings of affection, expressions of the libidinal drive are resisted by staff. One of the strategies to manage intense affection is the fragmentation of work which reduces the possibility of forming a social bond between staff and patients (Menzies Lyth, 1988, Fink, 2007).

If, out of sentimental empathy, the analyst becomes hostage to the presenting symptom, although initially the analysand will experience the analyst as empathic, eventually the psychoanalytic symptom proper will appear in acting-out outside the session or in boundary violations, countertransference experiences/enactments, or in inappropriate self-disclosures of the analyst within the session', (Moncayno, 2008)p185. The necessity and value of the initial therapeutic alliance contains a risk if staff colludes with the patient.

'The initial belief in and empathy for the symptom and the storyline has to be purely strategic, or a strategy within the transference for purposes of establishing a therapeutic alliance' (Moncayno, 2008)p186.

4.2.4 Resistance of the mental health services

The analyst recognises that it is the subject of the unconscious that knows, not the ego of the patient but, for the time being, pretends the ego knows what he/she is talking about. Therapeutic alliance is an alliance with the patient's ego defences, 'typically a strategic alliance at best', (Moncayno, 2008)p186. The staff could act from a place of not knowing, when met with the patient's demand in the transference for a subject supposed to know. A more ideal approach by staff would be to adopt the position outlined by Nicola de Cusa (1401-1464) in the *Docta Ignorantia* (Nicolai de Cusa Opera Omnia, 1985), an acknowledgement that knowing is not knowing. Mental health staff resist the subject of the unconscious, remain in the position of knowing, supporting this with the illusion of treatment that cures promoted through their University discourse, a manualised understanding of the psyche outlined in the DSMIV (American Psychiatric Association, 1994). This activates the emergence of

hostile and negative transference as the relationship is unmanaged, the unconscious unexplored, the knowing unconscious subject unheard, instead the unknowing ego speaks.

Services, operating from a fixed general knowledge base, opt to manage symptoms instead of relationships.

‘In the analytic situation, this truth is brought forward by a renunciation on the part of the analyst. If the analysand claims to know and that the analyst does not, the analyst still responds – without self-consciousness – from the place of a knowing that does not know that it knows. The analyst needs to acknowledge that the individual knows pointing in the direction of unconscious knowing by the subject and not the ego’ (Moncayno, 2008)p158.

This demonstrates that conventional mental health approaches to the patient fail and the therapeutic alliance that required much work to develop is damaged or destroyed. Staff resistance to relinquishing the position of subject supposed to know is exhibited in mental health’s conscious ego to ego dialogue. It is maintained by the desire in the patient to be lead and the utilisation by staff of University and Master Discourses and results in scant motivation to change.

4.3 Transference love and hate

Freud (1917) argues that transference which is present in the patient from the start of the treatment operates for some time as ‘the most powerful motive for its advance’ (Freud, 1917b)p443, becomes a hostile and aggressive force. In the absence of opportunity to symbolically represent this, it is acted out in a hostile manner. Acting-out can consist of direct acts by the patient on their own body or attacks on staff. There is a constant concern in services about danger, aggression and violence and as a result training and research in this area is popular, with one systematic review identifying over 3,000 published studies in the period 1976-2004 (Richter, 2006). Richter et al’ (Richter, 2006) review suggests that staff knowledge and subjective feelings of security in handling aggressive situations can be improved as a result of training programmes, but the effects on aggressive incident rates are less clear. An Irish study exploring Consultant Psychiatrists’ experiences of assault, concluded that;

‘90% of respondents had been the victim of verbal aggression/intimidation/threatening behaviour while 55% had been physically assaulted’ (Kavanagh, 2010).

Incidents of aggression and violence can be reduced or averted when the opportunity to speak is included in staff intervention.

‘A psychodynamic therapy study compared the year before the start of psychotherapy with the year after the 12-month course of therapy was received in a group of poorly functioning outpatients. Among the 30 completers, there were significant decreases of violent behaviour, self-harm, severity of global symptoms, number of symptoms, use of illegal drugs, number of medical visits, time away from work, and hospital admissions’ (La’talova, 2010)p246.

Klein’s (Klein, 1998) infant psychically consumes and destroys the mother; Freud’s (Freud, 1913-14) primal horde killed and ate the father; Lacan’s (Leader, 1995) infant is alienated from the (m)Other and has a desire to feel whole again, but is threatened by the jouissance of the (m)Other. Transference, the drives Eros and Thanatos, the alienation from the (m)Other and the self, the initial social bond and the vicissitudes of life conspire to create a potent mix requiring understanding and management, however the literature indicates services are more likely to address the physical manifestation of negative transference that is acting-out, rather than addressing the subject-Other relationship.

Freud (Freud, 1915b) and Lacan (Lacan, 1994) place transference at the forefront of mechanisms in treatment.

‘The transference which whether affectionate or hostile, seemed in every case to constitute the greatest threat to the treatment, becomes its best tool, by whose help the most secret compartments of mental life can be opened’ (Freud, 1917b)p444.

In *Observation on Transference Love* (Freud, 1915b) places managing transference above interpreting patient associations as ‘the only really serious difficulties’ (Freud, 1915b)p159 to be met. Successful treatment is about the successful management of the subject-Other relationship, transference management is of primary importance in staff/patient engagement; engagement is a consequence of identification.

4.4 Identification and translation into symptom formation

Identification follows a similar pattern to symptom formation, occurring in three ways which involve the subject copying a pattern that he is exposed to, it may involve taking on an aspect of the other in order to get the attention of and hoped for love of the desired object. Team members and patients may adopt the symptoms of others in order to gain the leader's attention. The libidinal tie in the normal progression of events would transform from identification with another to a desire to be the desire of the Other - into an object choice. Symptoms are formed where repression exists; object choice reverts back to identification allowing the ego to assume characteristics of the object.

‘It is noticeable that in these identifications the ego sometimes copies the person who is not loved and sometimes the one who is loved’ (Freud, 1921a)p107.

Staff copy patients and the converse is also true, identification is partial and normally with a single trait of the object.

Identification is implicated in symptom formation when there is exclusion of the object choice in relation to the person being copied. What is copied here is a similar emotional display not some trait of the object or the subject the object desires. Organisational researchers and staff in mental health services frequently describe elements of contagion that occurs between staff and between patients (Colligan, 1979, Walter van Zalk, 2010, Joiner, 1999). A patient may display a symptom such as self-harm and other patients copy the behaviour ‘based upon the possibility or desire of putting oneself in the same situation’ (Freud, 1921a)p107. The taking on of the other's symptom is not out of sympathy but out of identification with another ego with which there is openness to a similar emotional experience, a contagious quality.

In the three forms of identification described by Freud (Freud, 1921a), Lacan holds that the unitary trait is a primordial symbolic term interjected to produce the ego ideal agreeing that in the first two ‘the identification is a partial and extremely limited one and only borrows a single trait from the person who is its object’ (Freud, 1921a)p107, emphasising that identification and symptom formation follow similar patterns.

4.5 Replacing the unconscious with the conscious

Symptoms function as attempts at a solution and carry displaced meaning rooted in a formation of the unconscious that requires uncovering and understanding. They serve as signposts. Psychoanalysis differs from psychiatry as it does not initially seek to remove symptoms. To effect change in symptom formation psychoanalysis enables;

‘Replacement of what is unconscious by what is conscious, the translation of what is unconscious into conscious’ (Freud, 1917b)p435.

This allows the lifting of repression and the removal of preconditions that form symptoms. This occurs through transference management via the discourse of the analyst; conversely a master discourse inhibits this process. Freud links the lifting of repression to the possibility of cure, a process in which the patient is transformed, not renewed, leaving them in a different position with a reduction in inhibiting unconscious material. Psychoanalysis facilitates the person to maximise their potential that would have been possible under ‘the most favourable conditions’ (Freud, 1917b)p435, the speediest way to attempt this would appear to be an attempt a cure through knowledge.

However the general knowledge of the University discourse alone will not prove a cure; it is not received instead of the unconscious knowledge but beside it, effecting little or no change.

‘We must rather picture this unconscious material topographically; we must look for it in memory at the place where it became unconscious owing to a repression that needs to be removed’ (Freud, 1917b).

Replacement of what is unconscious by what is conscious is achieved by working through the subject-Other relationship which transforms pathological unconscious formations into normal formations, following which solutions are possible.

4.6 Repression, resistance and transference

Repression is linked to resistance. Once repression has been identified resistance to its removal is addressed. This is done by bring it to the patients attention. Freud (Freud, 1915b) noted that when positive transference occurs the patient abandons their symptoms or pays no heed to them often declaring they are well (Freud, 1915b)p162.

‘Anything that interferes with the continuation of the treatment may be an expression of resistance’ (Freud, 1915b)p162.

The patient is supplied with appropriate anticipatory ideas to challenge resistance;

‘If I say to you: ‘Look up at the sky! There is a balloon there!’ you will discover it much more easily than if I simply tell you to look up and see if you can see anything’ (Freud, 1917b)p437.

Demonstrating that the anticipatory idea combined with maintaining the analytic position challenges resistance.

Making what is unconscious conscious via the management of repression and resistance appear straightforward with a well-motivated patient, however the process is complex.

‘Untamed instincts can assert themselves before there is time to put the reigns of transference on them, or that the bonds which attach the patient to the treatment are broken by him in a repetitive action’ (Freud, 1914b)p154.

The analyst’s work includes retaining the analysand in analysis as to overcome something it has to within range (Freud, 1912)p152. When staff fail to recognise and reign in transference the patient abandons faith in the treatment and the staff, however the patient may remain bound to them by the libidinal drive and externally imposed controls which dictate who and where services are delivered (Government of Ireland, 2001a, Expert Group on Mental Health Policy, 2006), contributing to negative hostile transference.

4.7 Repetition and truth

Lacan (Lacan, 1994) cautions against just seeing transference as a repetition reminding us that what cannot be remembered is repeated in behaviour and this is handed over to the analyst to reconstruct and disclose what is repeated (Lacan, 1994)p129. Similarly staff are exposed to patients and each other’s behaviour creating opportunities for reconstructing what is happening. Transference can function by the handed over of something for reconstruct, in seeking truth, power is transferred from the patient to the staff or from staff to staff. The patient follows

fundamental rules of engagement, treating the staff as the subject supposed to know, utilising excess libidinal energy in a demand for love. This perspective identifies the point at which transference appears; the point at which the locus of power to provide the answer that contains the truth of the subject takes place, a point where it is critical to operate from an analytic rather than a master discourse. There is a struggle between the staff and the patient which is a reflection of a psychical struggle, between the intellect and the instinct, between understanding and attempting to take action (Freud, 1912)p108. This struggle played out in the transference from Freud's perspective is the field on which 'the victory must be won' (Freud, 1912)p108.

'It is a fundamental principle that the patient's needs and longings must be allowed to persist in her, in order that they may serve as forces impelling her to do work and make changes' (Freud, 1915b)p165.

Mental health care adopting a holistic approach attempts to remove the patient's needs and longings failing to recognise that transference begins where free association ends.

'Transference is essentially resistance. The transference is the means by which the communication of the unconscious is interrupted, by which the unconscious closes up again. Far from being the handing over of powers to the unconscious, the transference is, on the contrary, its closing up' (Lacan, 1994)p130.

'The analytic relationship is based on a love of truth – that is, on a recognition of reality – and that it precludes any kind of sham or deceit' (Freud, 1937b)p248.

As outlined in Chapters 2 and 3 services are built on an illusion and operate in the imaginary realm, consequently staff, for survival, keep the truth at bay by whatever means are at their disposal. The analyst is required to use transference to allow truth and recognition of reality to emerge, the opposite of what is required in services. Lacan (Lacan, 1994) identified that truth is based on speech even when the speech is made of lies. The duality of speech, truth – lies, contains the possibility that the Other may be deceived; this is a real danger in analysis or any transferential relationship contained in the risk that the Other will engage in affect and truth hunting. Freud (Freud, 1921a) links the development of language to the formation of social bonds

and the libidinal drive and Lacan (Lacan, 1994) links and likens the deceptive quality of discourse and love.

‘There is one domain in which, in discourse, deception has some chance of success, it is certainly love that provides it model. What better way to assure oneself on the point on which one is mistaken, than to persuade the other of the truth of what one says!’ (Lacan, 1994)p133.

Part of the fundamental structure that we can borrow from love is the opportunity to deceive.

‘In persuading the other that he has which may compliment us, we assure ourselves of being able to continue to misunderstand precisely what we lack’ (Lacan, 1994)p133.

This is significant for staff, as they appear loved by the patients, a deception created as a resistance to the lifting of repression. The deception works and staff respond by lavishing knowledge on the patients that love them consequently they get paid with additional symptoms which maintain the illusion of treatment, services and their master position. Staff actions and service structure retain patients in mental bondage supporting their resistance to change.

4.7.1 Repetition and relationship

Freud locates this disturbance in the relationship between staff and patient arising from the patient transferring feelings of affection onto the analyst postulating that transference is easily recognisable in the case of a young female patient and a helpful practitioner where falling in love may appear to be a normal outcome if they are engaged in a relationship that involves much time alone discussing intimate thoughts and feelings.

‘The patient having transferred on to the analyst intense feelings of affection which are justified neither by the analyst’s behaviour nor by the situation that has developed in the treatment’ (Freud, 1917b)p441.

The same emotional relationship reoccurs even when the players diverge extensively from the obvious scenario. Staff are unprepared for disturbance in relationships with patients despite acceptance that patients have difficulties managing affective aspect of

their lives. A lack of recognition of transference leaves staff and patients confused about the source and required management of intense emotional states.

The analyst initially accepts the position of subject supposed to know to sustain the analysand as it is important to be able to believe that the Other has helpful knowledge.

‘Attempting to intervene in the patient’s transference of knowledge onto the analyst can lead to despair’ (Fink, 2007)p139.

The emergence of resistance, the overt appearance of transference requires a shift from the exploration of the patient’s memories to working through of the relationship. This is a pivotal movement; something previously in a supporting role is now centre stage. Lacan argue; that the ‘analyst speech is (always) heard as coming from the transference Other’ (Fink, 2007)p140. Now the patient is associating staff with an earlier significant Other and transference takes on a different difficult quality, it is something that has to be worked with and this work can only be performed through a linguistic exchange.

‘There is no position outside of language that allows us to discuss language as a whole without having to rely on language itself in our discussion – there is no way in which we can step completely outside the transference situation in order to discuss what is happening in the transference itself. The interpretation of transference is a vicious circle’ (Fink, 2007)p141.

Lacan proposed that interpretation of transference is generally pointless and only creates repercussions for the subject-Other relationship. Because staff’s speech is heard as coming not from the staff but from the transference Other it is not possible for the patient to hear an objective interpretation of transference.

The dualistic quality of transference, the ambivalence love or hate, is two sides of a unitary bond to the Other.

‘The hostile feelings are as much an indication of an emotional tie as the affectionate ones, in the same way as defiance signifies dependence as much as obedience does’ (Freud, 1917b)p443.

Menzies Lyth (Menzies Lyth, 1989) describes how hospital admission constitutes unconscious regression allowing simultaneously love and hate for the staff, they are simultaneously desirable and threaten annihilation due to the unconsciously promise of satisfaction, which requires them to be hyper-alert in their responses. The patient's overt reactions to the staff, has nothing to do with the person of the staff, they are about the patient's position. Very often it has to do with staff's reoccurring tendency to think it is about them when it is not or inversely thinking it is not about him when it is (Fink, 2007)p148. This error can be fatal for analysis and is frequently fatal in a conventional health care setting. Transference needs to be managed and recognised for what it is – a transportation of ideas from one register to another. If it is miss-assigned as an attack on staff there is the risk that the response will be to counterattack driving the patient away or if the patient has a genuine grievance misunderstood as transference there will be a shutting down of therapeutic work.

The presence of transference 'constitutes an objection to intersubjectivity' (Fink, 2007)p149. Analysis is not about two subjects meeting and working through a process, one has explicit direction to free associate to give reign to the unconscious, the other has to set their subjectivity aside and allowing the projections of the patient to surface; 'the analyst must accept any and all projections' (Fink, 2007)p152. This keeps the analysis on track in the symbolic as opposed to the imaginary realm. Lacking knowledge of the unconscious and transference management skills poses significant risk for staff and patients, particularly as they operate from the certainty provided by the Master discourse.

4.8 The function of transference and certainty

Lacan proposes that transference gives access to part of our being to which there is no access in consciousness.

'For this indeterminate of pure being that has no point of access to determination, this primary position of the unconscious that is articulated as constituted by the indetermination of the subject - it is to this that the transference gives us access, in an enigmatic way' (Lacan, 1994)p129.

The subject is founded on uncertainty, which has a disconcerting effect and in seeking certainty transference emerges.

‘The subject is looking for his certainty. And the certainty of the analyst himself concerning the unconscious cannot be derived from the concept of transference’ (Lacan, 1994)p129.

The patient seeks certainty, an instruction about how to recover; similarly staff seek certainty in evidenced based medicine, certainty does not exist. Symptoms have meaning and serve a function for patients; evidenced based medicine has meaning, giving staff a degree of certainty, that they are the subject supposed to know.

The early work of analysis may enable a patient to gain control over one set of symptoms only to find that some new formation emerges. This is the point where treatment takes advantage over the patient (Freud, 1917b)p444. The treatment does not put a stop to the development of illness but it reaches a point where the new productions of illness shift to a single point the subject–Other relationship. Act II of psychoanalysis commences with heavily disguised transference taking central stage. The analyst is an interactive audience for this production and is no longer concerned with the narrative told in Act I, instead he is concerned with a new form of neurosis which replaces what originally presented (Freud, 1917b)p444. This demonstrates the divergence between psychiatry and psychoanalysis. Psychiatry’s observation and classification, its application of subject supposed to know attempt a cure founded on the narrative of Act I while psychoanalysis concentrates on Act II the subject–Other relationship as a process to bring knowledge already residing in the patient’s unconscious into consciousness.

4.9 Transference neurosis

Transformation of original neurosis into transference neurosis is not the ultimate aim of analysis; it is the pathway towards recovery. Symptoms need to be reviewed as their original meaning has been replaced in relation to transference. Some original symptoms may have disappeared and only those finding meaning in relation to transference persist. This is problematic for the staff’s concentration on symptom removal, as the decreased presentation of symptoms allowing staff to celebrate the success of their treatment. Signs of transference neurosis are categorised as the development of dependency and institutionalisation giving the staff reason to discharge the patient at the earliest possible moment. Freud (Freud, 1917b) initially postulated that mastering this new neurosis will coincide with getting rid of the

original illness that brought the patient to treatment – the task of analysis will be complete.

‘A person who has become normal and free from the operation of repressed instinctual impulses in his relation to the doctor will remain so in his own life after the doctor has once more withdrawn from it’ (Freud, 1917b)p445.

Withdrawal has implication for the staff, if the patient resolves his transference neurosis and gains a level of freedom from his troublesome symptoms he can withdraw from the services rendering staff redundant, constituting a loss for staff.

4.10 Intellectualisation versus relationship – drives and libido

Symptoms provide substitute satisfaction for libido; the libido operates in the struggle between independence and dependence. To progress analysis from Act I to Act II a libidinal cathexis of object is required, the patient’s ability to invest in or love the Other is essential implying a prerequisite that the level of narcissism in the staff or patient is not a barrier to this work.

‘Sufferers from narcissistic neurosis have no capacity for transference or only insufficient residues of it’ (Freud, 1917b)p447.

They find it difficult to be part of a group as members are bound together by love, love for the leader. Lacan (Lacan, 1994) emphasises this aspect of love but argues that love is a deception that allows us to convince the Other that he has what we lack. This poses real danger for staff particularly as they have taken up the position of subject supposed to know, they are deceived by the quantity of libido expressed by patients believing they can fill the lack, trapping themselves in a position where there is no need to question the knowledge they possess. Instead they do the opposite, utilise the quantity of libido as a verification that the knowledge is correct, contributing to the illusion, which amounts to a self and subsequent deception of others that they know the answers.

4.11 Working with transference to gain a cure

Psychoanalysis also claims to know, however the claim is radically different as it is knowledge of unconscious process not the truth of the subject. Freud’s (Freud,

1937b) defence is that analysis is a process that produces a state that would not occur naturally in the ego.

‘All repressions take place in early childhood; they are primitive defence measures taken by the immature feeble ego. In later years no fresh repressions are carried out; but the old ones persist, and their service continues to be made use of by the ego for mastering the instincts. New conflicts are disposed of by what we call after-repression’ (Freud, 1937b)p227.

Psychoanalysis enables the ego to undertake revision of old repressions, some are deconstructed and others are reconstructed with more solid material.

‘Analysis is the subsequent correction of the original process of repression, a correction which puts an end to the dominance of the quantitative factor of instincts’ (Freud, 1937b)p227.

Psychoanalysis recognises that removing some and strengthening other repressions does not eliminate the strength of instinctual forces but strengthens the ego to keep these qualities of the id in check. Analysis’ claim to cure neurosis by exerting control over the instinct, ‘is always right in theory but not always in practice’ (Freud, 1937b)p229 as the strength of instinct is a factor in the extent of change that can be achieved.

The mother’s sense making of the preverbal infant’s subjective experience depends upon her capacity to accurately interpret the intensity rhythm and form of her child’s internal affective states. Mothers need to affectively attune themselves to their infants to make sense of nonverbal behaviour. This implies that for therapist treating adult regressed patients is the necessity to pay attention to patients’ preverbal and nonverbal subjective experience, to take maternal affective attunement into account (Dosamantes-Beaudry, 2007). Staff are required to make sense of patients’ actions taking into account subjectivity and the unconscious and to address this through transference management as opposed to simply addressing current symptoms and appealing to patients’ intellect.

Freud (1937) reviewed the transforming quality of transference and identified three factors decisive for the success of psychoanalysis;

‘The influence of traumatic aetiology. The relative strength of the instincts. The alteration of the ego’ (Freud, 1937b) p234.

In *Analysis Terminable and Interminable* (Freud, 1937b) the concern shifts to male and female positions. Masculine protest, (fear of castration), is presented as preventing the male from subjecting to a father-substitute, leading to stronger transference resistance and refusal to accept that the analyst has played a part in his recovery. The female’s wish for a penis which cannot be fulfilled in analysis leaves her with an internal conviction that nothing can be done to help her. There is resistance from both sexes to participate in analysis which may or may not appear as transference preventing change. This is not a dismissal of analytic treatment but recognition of biological reality, a constant Freudian concern, highlighting the task of giving the patient every opportunity to work with and on his/her attitude to biological reality. Lacan’s shift to a structural conceptualisation of male/female positions suggests that the psychical disposition of the individual is not biologically dependent but aligned to the internalisation of the name of the father, allowing a radical reconsideration of the individual’s position in transference. When the theory is unlimited by a biological given and reconstructed around a law of the unconscious, the analyst is freed to work with the individual’s truth. This argument can be extended to the staff, the individual’s unconscious structure overrides biological reality and socially attributed positions; for example the social attribution of nursing as a female profession and medicine as male. Social reality presents a different picture and psychoanalysis acknowledges that the strength of transference can overlook a biological given in its search for an available object.

4.12 Transference and the Institution

Freud (1912), Menzies Lyth (1989) and Main (1957) link the regressive course that the libido takes and how this revives the subject’s infantile imagoes in particular with staff. Staff strivings to demonstrate an evidence base for practice has at its core a futile erotic quality, the drive towards evidence based practice is a defence against the erotic nature of health care encounters and a confirmation that society finds that;

‘Things that have to do with love are incommensurable with everything else’
(Freud, 1915b)p160.

The challenge of being loved or hated is too great and results in a flight into science, which in its failure to provide a workable method for managing the subject-Other relationship leaves staff in a therapeutic and theoretical vacuum where engagement with the patient is kept to a minimum.

‘A disproportionate amount of nursing time is taken up by administration and time spent talking to patients is minimal, where interactions do occur they are neither purposely therapeutic nor theoretically informed’ (Cameron, 2005)p65.

Similarly accounts from social work also identify the distancing between the social worker and the patient;

‘Moving beyond our practice, the more difficult tasks confronting lie in how we adapt to and shape the changing landscape of practice. There is an on-going need to become political to protect the clinical’ (Goldstein, 2009)p13.

Resistance utilises transference as a weapon, the common phrase that love hurts resonates for all of us. Transference which is unrelenting and intensive is an effect and an expression of resistance (Freud, 1912). The libido which we are required to work with, but which has held onto the infantile imagoes as templates plays a significant part in the day to day work of staff, particularly when they enter into a relationship with the resistance it brings forth. Without a theoretical framework that acknowledges its libidinal content staff resist and avoid contact with patients.

Freud places a special emphasis on the emergence of transference in the institution particularly when the treatment regime is non-analytic.

‘Transference occurring with the greatest intensity and in the most unworthy forms, extending to nothing less than mental bondage, and moreover showing the plainest erotic colouring’ (Freud, 1912)p101.

Manifestations of transference in the non-analytic institution cannot be attributed to the process of psychoanalysis instead they arise out of the neurotic condition, love appears as hate. Transference appears at a number of key points in the institution, in the process of identification with the ego ideal, as an outcome of the development of therapeutic alliance; that is the shift from a neurosis built around symptoms to

mediation of a subject–Other relationship and in crisis evoked by transference management failure culminating in incidents of acting-out.

Patients present to services for a variety of reasons and often the manifest issues, relationship, poverty, stress, social circumstances, family disharmony, instead of underlying neurotic, perverse or psychotic structures, are the issues that services identify as worthy of addressing. By addressing manifest issues service providers are acting as if they are some benevolent powerful person whose demands are met in an unquestioning manner by others and who has the ability to make problems vanish (Freud, 1917b). Benevolent attitudes are complicated by taking a casual approach towards neurotic, perverse and psychotic structures and the meaning of symptoms. The clustering of symptoms to create diagnosis categories (American Psychiatric Association, 1994) as a guide to treatment, more often than not a chemical solution, attempts to addressing symptoms not the subject–Other relationship. Freud (Freud, 1917b) described this as casual therapy and predicted the introduction of chemical solutions;

‘Suppose now, that it was possible, by some chemical means, perhaps, to interfere in this mechanism, to increase or diminish the quantity of libido present at a given time or to strengthen one instinct at the cost of another - this then would be a casual therapy in the true sense of the word’ (Freud, 1917b)p436.

This is a combination of taking the position of big Other and stagnating in a discourse which fails to address patient and staff drives.

4.12.1 Resistance in the institution

Resistance in the institution frequently goes unrecognised;

‘The breaking out of a negative transference is actually quite a common event in institutions. As soon as a patient comes under the dominance of the negative transference he leave the institution in an unchanged or relapsed condition’ (Freud, 1912)p106.

Readmission rates in Ireland remain high, readmitted patients are more vulnerable to being trapped in the system than first admissions, evidenced in the argument that the translation from a presentation of the patient’s original condition brought about by a

favourable therapeutic alliance to a transference neurosis is met with dismissal. When the patient already discharged and dismissed re-enters the system they bring with them a history of staff's countertransference and commence an uphill battle to be considered as anything but a failure to comply with the treatment regime. Erotic institutional transference has an inhibiting effect because it is glossed over instead of being exposed. It is manifested as a resistance to recovery, a resistance against the manifest reason that the patient entered the system. The expectation that this resistance would drive the patient out of the institution has a contrary effect; it helps to keep him there by keeping him at a distance from life.

‘For from the point of view of recovery, it is a matter of complete indifference whether the patient overcomes this or that anxiety or inhibition in the institution; what matters is that he shall be free of it in his real life as well’ (Freud, 1912)p106.

The institution structured to maintain illusion is unconcerned with real life.

4.13 Transference and praxis a two way street

For Lacan the concept of transference;

‘Is determined by the function it has in a particular praxis’
(Lacan, 1994)p124.

By recognising transference exists and effects treatment, staff could recognise it as a two way street where the traffic flow is dictated by the concept of transference. The patient locates the possibility of certainty and truth about themselves in the Other from which they got speech and may now get truth; staff appear content to take and hold this position. The patient's investment is met with a paucity of therapeutic contact, regular staff-patient interactions, informed by theory, is antithetical to the therapeutic aspirations of patients who increasingly are asking for someone to talk to (Cameron, 2005, Policy., 2005, Edginton, 1998). Patients want to speak and staff resist listening thus avoiding the excess anxiety provoked by the patient's condition, this does not prevent the emergence of transference but forms fertile ground for the transformation into hate and the emergence of negative countertransference.

4.14 Working with countertransference

There is a difference between the position of analysand and analyst; the analyst should be adequately prepared to conduct the work of analysis. This preparation has three essential components, academic, personal analysis and clinical supervision. Gordon (Gordon, 2005) cites Money-Kyrle's (1956) interpretation of Freud's argument in favour of personal analysis as a requirement to explore personal complexes and resistances which may skew the relation that the analyst has with the patient;

'Now to a parent, a child stands, at least in part for an early aspect of the self. And this seems to me important. For it is just because the analyst can recognise his early self, which has already been analysed, in the patient, that he can analyse the patient. Being in touch with the patient requires being in touch with similar fixations, defences, impulses, fantasies and conflicts in oneself,' (Gordon, 2005)p411.

This argument, along the lines of 'know thyself', enables the ability to distinguish what is emerging from the self as opposed to what may be considered as an introjection of material from the patient is supplemented by continuous professional development, on-going clinical supervision and personal analysis.

As a counter argument there is a narcissistic stance in believing that you can be in touch with how someone else experiences the world. Fink (Fink, 2007) relates this to Fliess' (1942) concept of 'trial identification' where the analyst tries to imagine being in the place of the analysand, to wear his shoes.

'People differ significantly from each other and unless, we are incredibly imaginative or have unbelievable vast experience with people from virtually every walk of life, we will never be able to truly imagine what it is like to be someone else' (Fink, 2007)p163.

While it may be possible for the mother to be completely in-sync with her infant for a period of time, particularly before the infant develops a sense of self and separateness, it is a tremendous assumption and complete misunderstanding that this state of complete understanding can be replicated later. However regression as a result of overwhelming anxiety leaves the patient desiring completeness in the opportunistic relationship with staff that adopting a parental approach enhances this.

Dresser (Dresser, 1985) argues for a shift from what he calls the original definition of countertransference, the analysts unresolved transferences to patients (Dresser, 1985), proposing a wider definition which would incorporate;

‘All the analyst’s feelings towards the patient, and as Hanna Segal pointed out, most of those feelings would be unconscious. The analyst’s unresolved transference to his patient would certainly be part of the total feelings, but the analyst’s feelings would also include what the patient projects into him, and also simply what the patient’s behaviour makes him feel’ (Dresser, 1985)p19.

Two problems are identifiable with this misunderstanding. Firstly, feelings are a conscious experience. Secondly, Fink’s (Fink, 2007) critique is implicated in Dresser’s (Dresser, 1985) definition. Dresser’s (Dresser, 1985) example of a countertransference situation evokes Klein’s concept of the ‘total situation’ (Joseph, 1985);

‘With this patient, her tone, her use of words as action, the atmosphere engendered in the session, and my countertransference are often more reliable clues to what might be happening than the content of her words’ (Dresser, 1985)p22.

There is a real slippage here in Dresser’s (Dresser, 1985) approach. He steps outside of the patient’s discourse and commences the analysis of feelings, ‘reliable clues’ a trip into the imaginary realm of what is happening for the patient. Supporting this approach Dosamantes-Beaudry (Dosamantes-Beaudry, 2007) cites Stern (1985) as maintaining that the mother’s has the capacity to make sense of her preverbal infant’s subjective experience suggesting that mothers needed to affectively attune themselves to their infant in order to make sense of their infants’ nonverbal behaviour. The mother’s role in making sense of her child’s affective state cannot be denied, however staff can only have a partial achievement of this position, unconsciously equated or equating themselves with the (m)Other, they need to recognise that they are a temporary partial substitute. The child also engages in sense making, the external imposition of desire and consequential alienation. There is repetition for the patient of feeling alienated while simultaneously experiencing the subject who is supposed to know as an overwhelming threat, while wishing to be desired by them. This explanation of the mother’s role does not account for the emergence of desire in the infant via encounters with the symbolic order.

In Dresser's (Dresser, 1985) and Dosamantes-Beaudry's (Dosamantes-Beaudry, 2007) accounts there is a privileging of the analyst's ability and the mother interpretation skills and a lack of recognition of the un-symbolised quality of desire which in analysis is addressed through symbolic rather than imaginary registers. Thus implying a requirement that staff should take a proactive role in enabling symbolisation and growth, allowing patients to locate their desire as opposed to maintaining regression dependency and stagnation as relevant change does not occur outside discourse. The analysis of feelings as advocated by Dresser maintains the patient as a minor (Dresser, 1985), (Foucault, 2006).

Fink (Fink, 2007) provides an alternative and symbolically based framework citing Lacan's description of countertransference as;

‘The sum total of the analysts biases, passions, and difficulties or even of his inadequate information, at any given moment in the dialectical process of analysis’ (Fink, 2007)p136.

This indicates a requirement that the analyst is at the least adequately informed through their academic pursuits to conduct the analysis. Countertransference can be understood as an effect of the analyst's theoretical biases alongside their pre-existing concepts of the psychical composition of the individual. It can also result from failing to take a position, being constantly swayed by new theoretical positions or some overvalued personal theory into which a formulation of the case is forced, (Cameron, 2005, Robinson, 1996a, Sullivan, 1998).

This promotes the requirement of clinical supervision, ‘the third ear’ as a quality control mechanism on practice. When understanding transference as occurring when symbolisation fails;

‘That is when the analysand is unable to go any further in his articulation of the ‘pathogenic nucleus’ – and countertransference is indicative of the analyst's failure to situate herself in the position of the symbolic other, having become bogged down in the imaginary relation (that is the dyadic relation between two egos)’ (Fink, 2007)p187.

This makes it apparent that transference/countertransference occurs at a point of failure in analysis. The patient is no longer able to articulate their story and revert

instead to an imaginary position which delays or inhibits the work of symbolisation. For services it may be more a case of the patient not being given the opportunity to articulate their story (Main, 1957, Menzies Lyth, 1988, Robinson, 1996a, Robinson, 1996b). Transference and countertransference can block the progression of the patient, highlighting their importance initially as something to be overcome, synchronously a red flag that the work will come to a halt unless something new happens to put it back on the symbolic track.

Lacan (Lacan, 1977) and latterly Fink's (Fink, 2007) radical approach to transference and countertransference reminds analysts to ensure that the work is conducted in relation to the symbolic order, the world of words as a practice of 'the symbolic function' (Lacan, 1977). A lapse into the imaginary realm, the realm of mental health service operations, results in the personality of the analyst taking the limelight (Fink, 2007)p188. The work becomes ego orientated, more about the staff than the patients.

4.15 Summary

A combination of biopsychosocial events dictates physical and psychical development. The initial formative relationship with an-Other usually (m)Other establishes an unconscious imago and mechanisms for intra and interpersonal relationships, central to this development is transference the mechanism that dictates the management of social bonds.

Anxiety is managed by regression and leads to the emergence and use of early unconscious libidinal attachment styles in current social relationships. In the primary relationship with the (m)Other there is a sense of completeness an experience of jouissance, an experience of overwhelming pleasure and the threat of annihilation. Patients and staff use the same unconscious process engaging in identifications and symptom formations simultaneously. Service occupants have strong libidinal ties to their leaders which are visible in the transference that emerges from the anxiety provoking nature of the work, the impossible act of caring.

Transference emerges as part of the social bond in the therapeutic alliance when the patient is no longer able to articulate the nucleus of his pathology indicating its intimate connection to something repressed, there is always resistance to making

conscious unconscious repressed material. Resistance may appear as the resistance of the staff. Progress is dependent on a therapeutic alliance which is initially built on an empathetic relationship founded in the belief in the subject supposed to know but required to move to a relationship which utilises transference in the search for the patient's truth. Transference has an erotic quality and is manifest as love or hate. In the institution, where staff avail of the University and Master Discourse, engagement in subject-Other relationships with patients is avoided due to the anxiety provoked by erotic energy and the exclusion of love from scientific discourse. This enables staff to remain in the position of subject supposed to know, therefore negative hostile transference abounds. Working appropriately with transference enables the emergence of the truth and allows access to parts of being to which there is no access in consciousness, this is inhibited by the Master and University Discourses. Transference appears at key points in the institution, in the process of identification with the ego ideal, as an outcome of the development of a therapeutic alliance, in the shift from a neurosis built around symptoms to the process of mediation of a subject-Other relationship and in the crisis evoked by the failure to manage transference which culminates in incidents of acting-out.

The libidinal quality of transference is firmly rejected and replaced by an intellectual relationship, an ego to ego approach. This is indicative of a narcissistic position which is constantly defended and reinforced by the excessive jouissance produced by service occupants. Analysis involves moving from an ego to ego relationship and enabling the ego of the patient to undertake a revision of old repressions. The result is a strengthening of the ego which enables it to keep the instinctual qualities of the id in check. However this theoretical position does not always account for the individual's experience of the work as there may be instinctual forces present that are not part of the current presentation which may give rise to later neurosis. This indicates that treatment has the potential to and is likely to fail particularly if staff are unequipped to manage transference, instead negative transference will be evoked.

Negative transference allows staff to remain in their narcissistic position and operate with the aid of certainty provided by the illusion of a scientific guide to diagnosis and treatment. The structure of the group around illusion leads to a recourse to intellect, dismissal of the patient or fostering of dependence. The challenge of being loved or

hated, the quantity of libidinal energy is too great and is met with resistance, both staff and patients are in mental bondage and there is a resistance to change and recovery by both. It is as if everyone operates in the imaginary realm where there is an overemphasis on staff's assumptions, affect hunting and nonverbal behaviours and a rejection of the symbolic register, the unconscious and analytic discourse.

There are key markers and events around which transference is evidenced. There is an undeniable chronological biological order to development but as we develop and grow from infant to adult the chronological order loses significance due to the lack of a clock in the unconscious. Psychological development is overwritten by the vicissitudes of life and the shift from the experience of completeness in the infant-mother dyad to fragmentation, incompleteness and anxiety. Dream analysis (Freud, 1900) demonstrates how elements in the unconscious interact by association which is outside of time and held in check by repression. There is a complex network of connections dictated by the subject's individual constitution within a given set of rules held in place by the structure of the symbolic order.

The desire to feel complete carries a threat of jouissance, equating to annihilation. This is managed by consoling ourselves with delaying pleasure through little deaths, a perpetual sense of completeness or holism is impossible if you desire to continue living. Life is only bearable if jouissance is curtailed. Desire implies we may wish for more, but a realisation of desire would imply our annihilation. Castration means that we give up on the totality of jouissance and that the totality is replaced by a limited pleasure. Every construction in society and culture including mental health services is a movement towards holism and totality which is under constant threat of being destroyed by internal and external sources, when the internal threat is excessive we split it off from the self and project it outwards onto the Other, we utilise transference. Biological development is inevitable it cannot be halted, unless we take the place of the anorexic¹⁰ or suicidal patient. Social and cultural development is also inevitable as we are born into a social and cultural group which continues to exist after we die. The subject is formed in a pre-existing external structure and internally forms as a neurotic, psychotic or perverse being. The psychotic does not engage with

¹⁰ Anorexia is used here as a term to define a rejection of both physical and psychological sustenance.

and remains paranoid about society and culture. The perverse subject dares to do what the neurotic only dares to dream about; challenges the law.

‘The neurotic has difficulties submitting to higher levels of the hierarchy, and difficulties dominating lower strata for him there is discordance between desire and the law. The average neurotic submits to the law in the sense that the Other is the premise for speech; the neurotic must take into consideration what the particular other understands and what he wants from him’ (Hyldgaard, 2004).

The Other's demand for coherence, the question of what the Other understands, is cause for worry for the neurotic and this controls his speech.

The neurotic is constantly engaged in managing anxiety, recognising that holism cannot be achieved, but through the processes of love and work manages a tolerable existence built on a promise that there is another Other in which jouissance can be found. Consequently transference helps us form social bonds which are expressed through actions and language, bonds that are overwhelming for the psychotic and problematic for the perverse subject. Feeling anxious and assailed by the vicissitudes of life the subject has recourse to mental health care and seeks a subject supposed to know. The subject supposed to know in mental health services utilises the University and ultimately Master discourse barring the individual from their truth. The powerful instinctual libidinal drive is rejected and re-emerges in an ambivalent form or appears as hate. The essential element of service provision is providing care that allows the patient to move from their symptom controlled status into a therapeutic relationship with the care provider. In non-analytic institutions this process appears to be absent or at the best limited in its provision and delivery, consequently, transference inevitably emerges in a negative form, creating fertile ground for rejection of the unconscious, the growth of resistance, repetition and repression, hatred, illusion and narcissism maintaining a hostile stagnant environment.

4.16 Conclusion

This and the preceding chapters explored literature pertinent to the aim of the study; the investigation of the management of transference within mental health services, I provided evidence for the unconscious and its actions. Psychoanalytic theory in relation to transference, to individual's intra and interpersonal relationships and the translation of transference from individual to group psychology were explored. Definition for psychoanalysis, the unconscious, the structural framework of the symbolic, real and imaginary registers and the four discourses were provided. The structuring effect of language was exposed. The relationship between transference, love and instinctual drives was described. Links were made between psychoanalytic theory and the current structure of the Irish public mental health service. The role of transference in identification and the creation and maintenance of social bonds has been presented. Essential elements of group psychology; identification, projection, the ego ideal, truth and illusion, the power of affects and the role of the leader explored. Finally the process of working with transference was addressed. The next chapter will explore a research methodology which will be used to investigate transference management in the study setting.

Chapter 5 Research Methodology

This chapter outlines the research methodology for the investigation of transference in the delivery of Irish adult public mental health services. Despite the wealth of material in relation to psychoanalysis as a theory of the human condition and treatment method there is a comparative lack of literature describing psychoanalysis as a research methodology. Consequently this chapter explores relevant aspects of psychoanalysis, science and research in order to describe how data can be collected by recognised research methods and analysed psychoanalytically. Following an introduction to the research process the chapter reviews the philosophy underpinning the study, the dominant research agenda in mental health and its relationship to psychoanalysis. Psychoanalysis as a qualitative methodology is examined in relation to data collection, rigor, subject-Other relationship and organisational research.

5.1 Conceptual frameworks

Research is an activity, based on intellectual investigation of a subject aimed at discovering new knowledge or verifying existing knowledge and requiring the application of a recognised method underpinned by a scientific paradigm, a quantitative or qualitative framework. The concept of a paradigm in science was introduced by Kuhn (Kuhn, 1970) who described a paradigm as a world view that stands for the beliefs, values and techniques shared by the members of a community.

Paradigms shape how we perceive the world and are reinforced by practitioners (Chalmers, 1982). Within the research process the beliefs a researcher holds reflect the way they research is designed, data collection methods, data analysis and the presentation of findings (McLeod, 2002). It is important for the researcher to recognise their paradigm as it enables them to identify their role in the research process, determine the course of the research project and distinguishes it from other perspectives. Cutcliffe and Ward (Cutcliffe, 2003) argue that one paradigm is neither, better or worse than the other as they only serve to enable the addressing of different questions. Research commences with the formation of a topic from which aims and objects are developed, findings contribute to existing knowledge or generate new knowledge.

‘The acceptable method for developing a science is the traditional research process, quantitative research’ (Burns, 2001)p10.

Within health care professions there is a tendency for different professionals to preference one approach to research over another, this preference is driven by factors such as the profession’s explicitly stated purpose, for example treatment or care, or to verify and justify theory underpinning the profession (Beins, 2004). In organisational research the term paradigm encompasses three levels, philosophical, social and technical. At a philosophical level organisational theories contain five sets of assumptions in a subjectivist/objectivist dimension; ontological, epistemological, axiological, methodological assumptions and assumptions about human nature which all influence the research process (Williams, 1998). Ontology refers to the nature of social reality that is real and external to the individual, labels and concepts that are used to structure reality (McLeod, 2002, Williams, 1998). Epistemology refers to the nature of knowing and construction of knowledge. Axiological assumptions relate to the role of values in research.

‘The social world can only be understood by obtaining first-hand knowledge of the subject under investigation’ (Williams, 1998).

5.2 Philosophy

Philosophy is the study of knowledge, thought, and the meaning of life.

‘Additionally it is understood as the particular doctrines of a specific individual or school relating to these issues, thirdly as any system of belief or values and finally as a personal outlook or viewpoint’ (HarperCollins, 2003)p613.

Central to the psychoanalytic belief system is the unconscious.

‘Freud developed a theory of the mind that has come to dominate modern thought. His notions of the unconscious, of a mind divided against itself, of the meaningfulness of apparently meaningless activity, of the displacement and transference of feelings, of stages of psychosexual development, of the pervasiveness and importance of sexual motivation, as well as of much else, has helped shape modern consciousness’ (Audi, 1999)p331.

Psychoanalytic writing deliberately attempts to return the reader to his own thoughts whatever their quality is, its emphasis remains subjective it aims ‘to evoke by

provocation' (Fonagy, 2000)p3, promoting a concern with the subjective experience of the researcher, the researched and subsequent readers of the study (Parker, 1992, Dravers, 2004, Ragland, 2004).

Freud (Freud, 1913a) believed that philosophers had taken up one of two positions in relation to the unconscious;

'Either their unconscious has been something mystical, something intangible and undemonstrable, whose relation to the mind has remained obscure, or they have identified the mental with the conscious and have proceeded to infer from this definition that what is unconscious cannot be mental or a subject for psychology. These opinions must be put down to the fact that philosophers have formed their judgement on the unconscious without being acquainted with the phenomena of unconscious mental activity, and therefore without any suspicion of how far unconscious phenomena resemble conscious ones or of the respects in which they differ from them' (Freud, 1913a)p178.

Similarly Lacan opposes linking psychoanalysis to the totalising explanations of philosophical systems, linking philosophers with the discourse of the Master, the opposite to psychoanalyst's working with the unconscious validating evidence by identifying repetitions and in the clinic by verification with the subject. Evidenced through Audi (Audi, 1999) the position of philosophy in relation to the unconscious has shifted since Freud's (1913) commentary. The philosophy of the unconscious radically repositions man's concept of himself as it contains the message that the individual is not the master of himself, placing a question mark over free will. The unconscious is imposed on the individual from outside via the language of the Other therefore it creates internal conflict between the unconscious desire of the subject, the consciously expressed desire to have free will and the compulsion to repeat leading the subject to reject the notion of an unconscious as it insults conscious beliefs. This appeal, to consciousness and individual desire is evidenced daily in our attraction to goods, to what is being sold to us, the message that we can choose to be whoever we want is used to full effect by marketing agencies who capitalise on the real gap that exists between the desire for free will and the conflict created by an unconscious. 'I think therefore I am,' has been cleverly paraphrased by Kruger to read 'I shop therefore I am' (Kruger, 2010) and could be further rewritten as I don't think therefore I shop. Jouissance is in-bedded in cultural and social practice resulting in a surplus;

‘Modern society increasingly precludes us from conceiving of enjoyment except through a cultural or societal Other leading to a paradox. Our own jouissance is positioned through the Other’s and therefore we look to increase the jouissance of these societal Others. Yet we also seek to appropriate the Other’s surplus for ourselves’ (Bicknell, 2005)p7.

Philosophy is frequently equated to moral and ethical codes of practice, a central concern in the research process. Beliefs about the human condition, our own and others unconsciously dictate how we respond towards others. Freud (Freud, 1921a) illuminated the origins of morality, religion, and political authority showing a particularly concerned with the effect on the individual’s ethics by the group.

‘Morality in particular he traced to the internalisation (as one part of the Oedipus complex) of parental prohibitions and demands, producing a conscience or superego (which is also the locus of self-observation and the ego-ideal)’ (Audi, 1999)p333.

The unconscious plays a significant role in morality through a required renunciation of instinctual energy achieved through repression to allow for order to develop and for society to operate effectively. The unconscious transmission of social bonds contributes to moral and ethical behaviour. The philosophy of psychoanalysis expounds that the energy for the achievements of art and science, hallmarks of a civilised society, is achieved through the sublimation of instinctual drives, a shift from narcissism to altruism. With its emphasis on the unconscious, psychoanalysis could be described as a philosophy of mind as it is concerned with mental phenomena and their relation to the structure of reality.

Central to psychoanalysis is the speech of participants, therefore the philosophy of language linguistic meaning and the function of language warrant consideration.

‘Contemporary philosophy of language centres on the theory of meaning, but also includes the theory of reference, the theory of truth, philosophical pragmatics and the philosophy of linguistics’ (Asay, 1999)p673.

For psychoanalysis the theory of meaning carries particular significance. Lacan’s structural and linguistic frameworks are central to a contemporary understanding of psychoanalysis, where the unconscious is understood as structured like a language. Within Lacan’s thesis reference is made to the meaning of signifiers; signifiers used in

intrapersonal conscious and unconscious sense making carry individual resonance for the subject. This signification of signifiers matches the plasticity in the formation of memory, consciousness as a serial phenomenon and unconsciousness as a parallel process (Peled, 2008).

Subjective experience shapes the world and the language we use for sense making gives each of us a unique understanding of how it operates. We unite together, form social groups through the libidinal drive and the medium of language but even within this we remain alienated both from each other and ourselves as language is imposed by an external source. Philosophy of language expounds the referential view that words mean by standing for things and that sentences mean because the parts correspond referentially to each other this is true and acceptable in a conscious understanding of language. But from an unconscious perspective the meaning of words and sentence have subjective significance. Therefore a philosophy of language is not merely about individual signifiers and signification but inclusive of their organisation into sentences and interactions, akin to the elements of metaphor and metonymy aspects of a psychoanalytic investigation. What is conventionally assigned by a social group in terms of language is relationally significant to the subject's utilisation of the conventions at their disposal.

Psychoanalytic belief in the individual and unconscious signification of language directs the discussion towards the issue of truth. Research aims to generate new or verify existing knowledge. Truth is central in a psychoanalytic investigation the truth of the subject, not necessarily what is expressed as true but the true meaning of signifiers, what can be discovered as true in the unconscious. Freud links language and truth, psychoanalysis is a construction of the truth. Lacan argues that the articulation of the truth is central in psychoanalysis, the articulation of desire (Lacan, 1993a)p144, valuing truth for understanding madness arguing that;

‘Modern science renders madness meaningless by ignoring the concept of truth’ (Lacan, 1993a)p153-4.

The philosophy of psychoanalysis is a philosophy of mind expounding the belief that the unconscious exists and infiltrates all aspects of intra and interpersonal existence in

which conscious mastery of the mind is an illusion. Neuroanalysis theory supports the emphasis placed on language by contemporary psychoanalysis providing additional support for the unique unconscious relationship between the subject and signifiers (Peled, 2008). Psychoanalysis, philosophy and science share the aims of finding truth and meaning, however psychoanalysis with its set of beliefs and values relating to the individual and society from which it expounds an ethical stance in relation to the subject places truth as a subjective qualitative standpoint.

Freud (Freud, 1921b) concerns himself with ethics and philosophy for psychoanalysis questioning the demand that as a science it should be linked to particular philosophical system or that as a practice it should be associated with a particular set of ethical standards (Freud, 1921b)p270. However he remained doubtful;

‘As to which philosophical systems should be accepted, since they all seemed to rest on an equally insecure basis, and since everything had up till then been sacrificed for the sake of the relative certainty of the results of psychoanalysis. ‘It seemed more prudent to wait, and to discover whether a particular attitude towards life might be forced upon us with all the weight of necessity by analytic investigation itself’ (Freud, 1921b)p270.

This prudence paid off as psychoanalysis with its particular approach to the unconscious and the meaning of life gained sufficient momentum to be recognised and listed as a philosophical position, however the question of an ethical stance remained open and later became the subject of a seminar by Lacan (1959-1960).

‘If there is an ethics of psychoanalysis – the question is an open one – it is to the extent that analysis in some way or other, no matter how minimally, offers something that is presented as a measure of our actions – or it at least claims to’ (Lacan, 1959-1960)p311.

Lacan’s actions were frequently criticised by his contemporaries and occasionally by his patients. Sometimes researchers forget or neglect that however valuable data is for research its value to the subject is even greater (Moore, 2009)p5. Lacan suggests that we consent to moral demands and links ethical behaviour to the fear of moral retribution from the group suggesting that moral and ethical behaviour is closely linked to the social bond;

‘Very often there is nothing more in the duties man imposes on himself than the fear of the risks involved in failing to impose those duties’, ... ‘Psychoanalysis teaches us that in the end it is easier to accept interdiction than to run the risk of castration’ (Lacan, 1959-1960)p306-307.

Lacan risked the social bond and ran the risk of castration in his treatment of Pantaine (Roudinesco, 2005)p35, as if he lacked internal critical judgement of his own actions. However his behaviour towards Pantaine precedes his later seminar on ethics which partially redresses his actions.

Lacan’s arguments on ethics and psychoanalysis revolve around their paradoxical quality.

‘Ethics essentially consists of a judgment of our actions, with the proviso that it is only significant if the action implied by it also contains within it, or is supposed to contain, a judgement, even if it is only implicit. The presence of judgement on both sides is essential to the structure’ (Lacan, 1959-1960)p311.

The researcher makes a judgment about the data and the participant makes a judgement about the analysis.

‘Morally responsible research behaviour is more than abstract ethical knowledge and cognitive choices; it involves the moral integrity of the researcher, his or her sensitivity and commitment to moral issues and actions’ (Kvale, 2009)p74.

5.3 The dominant research agenda in mental health

As stated above, in mental health there is a tendency for different professionals to preference one approach to research over another driven by the profession’s explicitly stated purpose. Much research in mental health involves exploration of the comparative benefits of treatments and is preferred by the medical profession where the aim is to treat conditions resulting in the creation of treatment protocols and concepts of best practice. The evidence base for best practice is based on, research evidence proving that a practice works; practitioners’ opinions about what works in practice; and culture and local context which determines if and how a practice works here and now (National Justice Chief Executive Officers’ Group and the Victorian Government Department of Justice, 2010). However, the dominant agenda measures biological markers and even when psychological methods are employed the tendency is to concentrate on outcome measures rather than the quality of relationships when a

range of methodologies selected to fit the questions posed and to gather relevant data are required (Brown, 2001). Parker (2005) argues that psychoanalytic theory takes the discipline of psychology beyond mere descriptions of behaviour (Parker, 2008b)p147. Influenced by Lacan's movement away from mainly therapeutic matters towards a 'more systemic investigation of psychoanalytic phenomena' (Glynos, 2002)p15, relevant data for studying transference is the speech and actions of participants. Much research relating to psychological approaches is concerned with the therapeutic effect of specific psychotherapeutic approaches which does not capture Lacan's consideration of a systemic investigation of psychoanalytic phenomena.

'Wilson (1993) suggested that the concept of the unconscious was marginalized by the American Psychiatric Association's (APA) Diagnostic and Statistical Manual III, which is a descriptive manual of psychiatric diagnosis' (Crowe, 2004b)p3.

A qualitative approach to gathering data initiated much of what we have learnt about the human subject through psychoanalysis and other psychotherapeutic approaches over the past 150 years.

'Freud's theories were partially derived from clinical or process work, in-depth interviews and life histories; Adolf Meyer (1866-1950) used and taught a detailed life history approach, and many of our current psychiatric diagnosis were derived from careful systematic studies of a small number of cases' (Goering, 1996)p491.

However the APA via the DSMIV (American Psychiatric Association, 1994) have determined the nature of psychiatry in three ways;

'There was a loss of the concept of the unconscious, emphasis was placed on a 45 minute cross-sectional interview rather than an unfolding of a life history over time; clinical relevance was narrowly constructed' (Crowe, 2004b)p3.

Foucault (Foucault, 1975) proposed that symptoms were defined in terms of visibility so that empirical evidence could be employed to support the existence of a disease model. The unconscious is characterised by invisibility making a narrowly constructed conceptualization infeasible. Additionally Busch (2010) argues that patients bear the burden of a failure by psychoanalysts of their treatment being rarely

considered as a treatment of choice for a mental problem in the current health care climate as there are many well-studied treatments with demonstrated efficacy.

(Hogan, 1999) claims that the dominant approaches to treating mental disorders have succeeded in proving it is that their failure to come to terms with the workings of mental processes (Hogan, 1999). Verhaeghe (Verhaeghe, 2007) argues that over the past four decades there has been an appeal for a scientific approach in psycho-diagnosis and treatment emerging from the crisis in psychiatry commencing with the antipsychiatry movement and resulted in the creation of the DSMIV (American Psychiatric Association, 1994), an attempt to provide an empirical base for diagnosis and treatment. The mental health field has progressively narrowed its perspective, focusing more and more on simple symptom clusters (PDM Task Force, 2006)p3. As a result of seeking out the visible aspects of a presentation the subject has become less visible and is replaced by disorders constructed on which researchers can agree. The Psychodynamic Diagnostic Manual (PDM) Task Force (PDM Task Force, 2006) argues that this raises issues of reliability and validity, markers for valid research outcomes, in diagnosis in mental health. The oversimplifying and/or reductionist approaches towards mental health phenomena in the service of attaining consistency of description and capacity to evaluate treatment empirically may have compromised the goal of a more scientific understanding of mental health and psychopathology. Parker (2008) argues that psychoanalysis is concerned with questions of form rather than content, that it focuses on the disjunction between consciousness and the unconscious and that it treats appeals to divine forces as a sign of pathology, and any expectation that psychoanalysis should frame its questions in the same way as other disciplines introduces tension into conceptual research apparatuses and into psychoanalytic writing (Parker, 2008b). Ignoring the complexity of mental life excludes the subject – the defining characteristics of the individual. The APA acknowledge that the desired reliability, especially among practicing clinicians, has not been obtained (PDM Task Force, 2006)p3, supporting the contention that clinicians operate from a qualitative as opposed to a quantitative perspective, despite the reality that most of the interventions being offered, chemical solutions, have been derived from quantitative research studies. The result is a limited qualitative perspective that does not acknowledge subjectivity and in particular the subject's intra-psychical life. These critiques have implication for the current drift toward

protocol driven services and evidence based practice. The obvious narrowing of the field will eventually result in a paradoxical effect where the demand for consistency, reliability and validity continues to exclude and will eventually annihilate the subject.

Verhaeghe (Verhaeghe, 2007)(p3) argues that the DSMIV diagnostic criteria are social constructs, based on social norms fulfilling the medical manner of dealing with symptoms - using sets of symptoms to construct syndromes, on which researchers can agree is a quantitative approach which provides the bases for understanding how mental health services are operationalized. The psychoanalytic approach is primarily concerned with the meaning of symptoms for the individual; a qualitative approach based on subjectivity as opposed to socially constructed norms.

‘In psychiatry, ‘psychic normality is understood in terms of average scores, standard deviation, and modal personalities’ (Verhaeghe, 2004)p7.

Quantitative methods treated in this manner can be used to calculate a graph of normality against which a person can be measured resulting in the prescription of a treatment which will return the subject to a socially acceptable state. Measurement of normality becomes the tool through which socially acceptable behaviour can be defined and consequently psychiatry and psychology become the ‘judges of social order’ (Verhaeghe, 2004)p11. The discourses of the University, the Hysteric and the Master conspire with each other, the discourse of the Analyst in contrast promotes a theory of human subjectivity and engagement which avoids judging social order opting instead for a descriptive account and a theory of change which is problematic if the requirement for validity is confined to an empirical test.

The conclusions of empirical evidence are based on;

‘Observations, instead of appealing to authority, faith, wishful thinking, armchair speculation or mere theoretical prediction’ (Sandell, 2001)p184.

Psychoanalysis gathers empirical evidence from participant’s speech and action and subjects it to a focused investigation based on a belief in the unconscious. The evidence from psychoanalysis is constructed from the speech and actions of

participants, verified against external reality, inclusive of shared cultural assumptions sociological and psychoanalytic knowledge (Hollway, 2007).

‘The unconscious is not amenable to empirical analysis therefore could be regarded as falling outside medicine’s field of interest. Psychiatry has always based its authority on the concept of the mind operating through the brain a material and therefore observable object’ (Boyle 1990 cited in (Crowe, 2004b)p4.

Lacan’s theory of the real, symbolic and imaginary orders demonstrates the impossibility of quantifying or qualifying all aspects of the subject-Other relationship; however acknowledging that part of being occurs in the Real, that we are barred from symbolically representing aspects of subjective occurring outside a linguistic framework, a research methodology that acknowledges subjectivity and evokes understanding emerges. Psychoanalysis is concerned with subjective experience, an evocative narrative which Nietzsche distinguishes from ‘boring empirical fact’, resulting in a turning away from what is appealing to a cognitive asceticism in order to ‘create a narrative that fills the gap in a person’s life’ (Fonagy, 2000)p3. This attempt to fill a gap results in research built on psychoanalytic theories that are judged on how well they fit our and the subject’s subjective experience.

‘That is not to say that the theories are not true, rather that they are metaphoric approximations at a subjective level of certain types of deeply unconscious experience’ (Fonagy, 2000)p3.

Psychoanalytic research remains primarily concerned with elucidating the subject-Other relationship as it occurs in a particular social context.

Polkinghorne (Polkinghorne, 1995) holds that qualitative research can be divided into narrative or paradigmatic forms, giving the researcher two options to work within however not all researchers confine themselves to this approach. Rennie (Rennie, 1992) uses a combination of paradigmatic approach alongside a narrative approach which allowed for the exemplifies of categories both through the voice of the researcher and the voice of the participant (McLeod, 2002)p81. While this is consistent with Strauss and Corbin (Strauss, 1990) recommendations in relation to using grounded theory it stands in opposition to Polkinghorne’s (Polkinghorne, 1995)

position. This demonstrates that without considering the question of competing paradigms between qualitative and quantitative research, within the qualitative field, differences coexist in what is believed about how a research paradigm can be utilised.

As previously argued, the maintenance of the status quo in the mental health service which ignores alternative ways of working and conceptualising generates an excess of *jouissance*, an intra-psychic payment for the work. This supports the contention that what is required is a return to a previous discovery, the unconscious, and psychoanalysis' contribution in identifying the significance of the intra-psychical life of the subject. Psychoanalysis is a qualitative method which includes a depth of exploration unfamiliar too or rejected by the dominant mental health treatment providers.

5.4 Considering and accepting a qualitative approach

‘Qualitative research is a systematic, subjective approach used to describe experiences and give them meaning’ (Burns, 2001)p61.

Approaches include phenomenological research, grounded theory, ethnography, historical research, philosophical enquiry and critical social theory. Data is generated through narrative descriptions, conversations that take place in naturalistic settings, development of field notes, recordings and documentary evidence. Methods within qualitative research designs vary depending on the philosophical orientation of the study.

‘The primary aim of qualitative research is to develop an understanding of how the world is constructed’ (McLeod, 2002)p2.

Qualitative research is subjective, it proposes that there is no single social reality, and that social reality, based on the perception of the individual, will change and evolve over time. In essence knowledge is contextual to a particular situation.

‘Qualitative research is a way to gain insights through discovering meanings’ (Burns, 2001)p61.

Quantitative research does not utilise numerical values to analyse data, data generated is descriptive and dependent on the skill of the researcher to interpret the data and organise it thematically.

5.4.1 Rigor

Qualitative research does not set out to test theory; theory emerges from the analysis, requiring a consistent rigorous examination of the data, similarly psychoanalysis from its inception fostered the belief that theory is generated by the clinic (Howitt, 2005). Freud initially presented case material as a means to demonstrate how psychoanalytic theory is generated, (Breuer, 1893b, Freud, 1901-1905, Freud, 1909, Freud, 1911-1913, Howitt, 2005), emphasising that in psychoanalysis the subject's relationship to the world takes precedence over the theory thus relegating psychoanalysis as a research methodology to third place behind the individual's being in the world which generates theory and a subsequent methodology. However, as in all approaches to the human condition, once sufficient evidence has been amassed, the theory and the method takes on a general acceptability giving them a status of their own.

‘Rigor is associated with openness, scrupulous adherence to a philosophical perspective, thoroughness in collecting data, and consideration of all the data in the subjective theory development phase’ (Burns, 2001)p64.

The qualitative researcher identifies and describes the meaning of experiences. Exploring the speech and actions of the subject in the context of their social and cultural setting fits seamlessly with the psychoanalytic approach to the subject. The perceived naturalistic space of psychoanalysis is the couch. However, previous researchers have all conducted psychoanalytic investigations outside the perceived traditional setting (Main, 1957, Freud, 1921a, Klein, 1998, Menzies Lyth, 1988, DeBoard, 2005, Long, 1997, Bicknell, 2005, Hollway, 2007, Burkard, 1999, Erlich-Ginor, 1998, Vanheule, 2003). In effect the researcher's task is to metaphorically take the couch to the setting.

‘The methods used in qualitative research are not new and have a long tradition in a variety of academic disciplines’ (Murphy, 1998).

‘It is essential that qualitative research is and must be based on empirical evidence or it cannot claim to be research’ (Brown, 2001) p350.

Earlier I argued that empirical evidence is based on observations that can be supported quoting Crowe's (2004) argument that the unconscious is not amenable to empirical analysis. However Crowe's (2004) argument only stands if the researcher confines support for qualitative data to biological and physical markers. Empirical evidence can be derived from the analysis of clinical experiences which show positive or negative results leading to dis/improvements in health-sickness ratings, decreases or increases in health care utilisation and in un/fulfilment of treatment goals.

'The psychoanalytic interview where knowledge production is not the primary purpose has been the psychological method for providing significant new knowledge about humankind. Freud regarded the therapeutic interview as a research method: It is indeed one of the distinctions of psychoanalysis that research and treatment proceed hand in hand' (Kvale, 2009)p41.

Recognising that the production of knowledge is part of the University discourse should caution the psychoanalytic researcher to structure their research aims towards illumination rather than education (Parker, 2005b). The subjective experience, an evocative narrative that fills the gap in a person's life is judged on how well it fits. There is an objective/subjective duality in this approach. The researcher/psychoanalyst recognises the appeal for objectivity while addressing the data from a subjective perspective by acknowledging operating from a particular belief system.

5.4.2 Psychoanalysis and the qualitative method

Both psychoanalysis and the qualitative method are open to criticism. Psychoanalysis since its inception has been subjected to criticism by the scientific community's argument that there is a problem with its evidence and method. Psychoanalysis privileges the unique discourse of the individual, as does the qualitative researcher in their transcription and analysis of all the utterances of their subject. The subject's unique discourse is taken into account 'inclusive of external reality' (Glynos, 2002)p31. The criticism of psychoanalysis as a practice where the analyst is always right, a heads I win tails you lose situation, was examined by Freud (Freud, 1937a).

‘If the patient agrees with us, then the interpretation is right; but if he contradicts us, that is only a sign of his resistance, which again shows that we are right’ (Freud, 1937b)p257.

‘The analyst interventions are like statements that can be verified by establishing a correspondence with some true state of affairs in an external reality which the patient or analyst was in a position to validate’ (Glynos, 2002)p32.

This validation against external reality, part of the process of normal science is identified by Hollway and Jefferson (Hollway, 2007) as integral to a psychoanalytic method.

Psychoanalytic researchers argue in favour of qualitative over quantitative methods as they fits with the traditional way of psychoanalytic work (Lievrouw, 2003a)p97.

‘Psychoanalysis provides a range of essential descriptions and constructs without which it would be far harder to talk about ourselves or to understand our own and other people’s lives’ (Fonagy, 2000)p2.

Qualitative research is a enables the researcher to gain insights ‘through discovering meaning’ (Burns, 2001)p61. It may also aim at the development of theory, the secondary gain; not necessarily a central focus of psychoanalytic work. Psychoanalysis’ discursive nature is a research method that gathers data, which expands our comprehension of the human psyche and should be inclusive of Parker’s (2005) argument that a Lacanian approach demands a different conception of what human being are (Parker, 2005a)p164, that includes recognising that people use and are used by language.

5.4.3 Repetition as data

Links between standard qualitative methods and the use of psychoanalysis to explore group behaviour can be found in the early foundations of the qualitative approach (Wallace, 1983). The transition from individual to group psychology includes the central principle that individual psychology is essentially group psychology. This principle alone supports the author’s approach to the investigation of transference by utilising psychoanalytic methods of investigation with the participants in their social and cultural context. This allows for a cautious claim of a shift that Freud displayed

in his work from the presentation of single case studies to metapsychological and anthropological works as Freud's anthropology is part myth constructed to justify difficult areas of theory and where not mythical in its origins has been conducted from a distant as opposed to an active field investigation.

Early anthropological work recognized the significance of an applied psychoanalytic approach (Wallace, 1983) commencing with Freud's earliest anthropological texts which investigate the unconscious structure of the human mind in the development of social structures. Works such as *Totem and Taboo* (1913) and *Moses and Monotheism* (1939) are anthropological texts; additionally *Jokes and Their Relation to the Unconscious* (1905), *The Interpretation of Dreams* (1900) and *Thoughts for the Times on War and Death* (1915) rely on both an investigation of the unconscious and society to promote his thesis. Freud recognised that psychoanalysis alone could not produce a 'weltanschauung' (world view) and therefore his writing draws from philosophy, psychology, medicine, science, anthropology and social observation in promotion the influence of the unconscious. This recognition contrasts with the concept of a scientific paradigm discussed above.

5.5 Organisational analysis

The evidence the group psychology is an extension of individual psychology allowed Freud and later researchers (Main, 1957, Bion, 1990, Menzies Lyth, 1988, DeBoard, 2005, Bicknell, 2005, Long, 1997, Comerford, 2010, Erlich-Ginor, 1998, Burkard, 1999, Vanheule, 2003), to put organisations on the couch. In psychoanalysis the analysand on the couch free associates in the presences of the analyst's floating attention. In this study the mental health services speak on a metaphoric couch and the researcher/analyst utilises floating attention offering an interpretation of a specific aspect of the unconscious life of the organisation. For example Rous & Clarke's (Rous, 2009) review of child psychoanalytic psychotherapy uses both psychoanalytic knowledge and Kuhn's concept of crisis in a science (Kuhn, 1970) to evidence anomalies in approaches to child psychotherapy firstly between Melanie Klein and Anna Freud and secondly in how learning theory established itself as a rival paradigm. The result of shifts in conscious agendas despite both psychiatrists and psychologists still finding the theoretical framework of psychoanalysis to be useful resulted in the development of briefer psychodynamic therapies, while the behavioural

paradigm evolved into the current dominant model of cognitive behavioural therapy resulting in an eclectic mix of paradigms, rather than one dominant heritage, which can be understood as unconscious adjustment in order to preserve a belief (Rous, 2009).

The primary intent of the application of psychoanalytic theories to organisations is to offer the opportunity to alter key relationships between and amongst organisational members, staff and patients, (Diamond, 1993)p20. Diamond's (Diamond, 1993) description of psychoanalytic organisational theory refers to it as a tool to understand organisational dynamics and for practicing organisational change and development.

‘It is a model of action research in that it builds and renovates its theory as an outcome of attempts to gain insight, heighten relationship awareness, and change actual organisations’ (Diamond, 1993)p20.

To engaging in a research project whose sole aim is discovering new or verifying existing knowledge is engagement in the university and not the analytic discourse. Analytic discourse is concerned with the truth of the subject aiming for a reconstruction of their world by the transformation of unconscious material to consciousness; a change from active engagement in the analytic process is inevitable, possibly unwelcome. The subject is given opportunity for action which due to resistance, the influence of the unconscious and in this case the potential to suffer a loss of jouissance may be met with inaction.

Using psychoanalysis to investigate an organisation differs to how that work is conducted with an individual client.

‘One analyses patterns of relationships (intersubjectivity) and individual perceptions of organisational experience’ (Menzies Lyth, 1989)p33.

The identity of the organisation is analysed. The researcher adopts an analytic position and is mindful to the history of the organisation particularly in relation to critical incidents. Denial and suppression of the realities of the organisation often go unidentified by its members resulting in stagnation in relation to development and a

reduction in effectiveness. Parker (2008) argues that papers written by theorists who are also practitioners;

‘Provide a particular vantage point on the intersection between psychoanalysis and psychology’ (Parker, 2008a)p160.

Once an institution has been established it becomes extremely difficult to change its essential structure, which modifies the personal structure of the individual for a short or permanent period of time. Menzies Lyth (Menzies Lyth, 1989) cites Fenichel (1946) concern with the impact of the institution on the structure of the individual;

‘Social institutions arise through the efforts of human beings to satisfy their needs, but they become external realities comparatively independent of individuals that never the less affected the structure of the individual’ (Fenichel (1946) cited in Menzies Lyth, 1989)p26.

Three kinds of analysis can be undertaken, the analysis of roles, structure and culture (Menzies Lyth, 1989)p34. Work culture analysis is related to psychoanalysis as it considers attitudes and beliefs, patterns of relationships, traditions; the psychosocial context in which work is conducted alongside interpersonal collaboration. Work culture analysis is concerned with patterns of relationships relating it to the social bond marked by transference management.

5.6 Psychoanalysis as a research tool

Lievrouw (Lievrouw, 2003a) argues that a combination of qualitative research and psychoanalysis is a productive method but cautions that success is not unconditional;

‘The prerequisite that conclusions should be coherent with psychoanalytic practice and psychoanalytic theory is crucial in order for them to be psychoanalytical meaningful’ (Lievrouw, 2003a)p98.

In contrast Fonagy (2000) argues that psychoanalysis has limitations as a form of research (Fonagy, 2000)p4, the researcher needs to establish for the reader the existence of the unconscious and at the same time rigorous research methodology needs to be employed. Lievrouw (2003) is concerned with the establishment of ‘a Lacanian research ethic’ (Lievrouw, 2003a)p99, proposing that the researcher has an ethical responsibility to answer the following question;

‘What do we want to know, and why do we want to know it?’
(Lievrout, 2003a)p99.

In psychoanalysis the patient seeks an analysis to get help with their symptom. This is turned around in the case of research when the researcher seeks the subject to gain an answer.

‘The primary difference between the two practices is that clinician interpret into the encounter, whereas researchers will save their interpretations for outside it’ (Hollway, 2007)p77.

From a psychoanalytic perspective the initiation of the analysis is reversed however according to Lievrout (Lievrout, 2003a) the structure of the process remains the same. Maintenance of the structure allows for the application of psychoanalysis as a research tool. A number of researchers (Menzies Lyth, 1988, Menzies Lyth, 1989, DeBoard, 2005, Main, 1957, Hollway, 2007, Vanheule, 2003) achieved Lievrout (Lievrout, 2003a) demand maintenance of a psychoanalytic structure through adherence to analytic discourse. Parker (2005) argues that a;

‘Lacanian approach to discourse has consequences for the way we think of ‘criteria’ for research’ (Parker, 2005a)p175.

A Lacanian approach requires a different perspective on the reading of the texts that encompasses the analyst’s desire to obtain difference resulting in an analysis that is structured by disagreement rather than agreement.

5.6.1 Psychoanalytic research and meaning

The search for meaning in the speech of the Other, is a first step in the analysis of data containing conscious and unconscious elements. Bracken (Moore, 2011) the advocate of post-psychiatry postulates a hermeneutic approach to understanding people in the mental health services. Reggio’s (Reggio, 2007) interview with Jean Oury emphasis that psychoanalysis should not limit itself to a single conceptualisation favouring an interdisciplinary approach to the clinic and research.

‘There is a blind spot a hole, ... in the history of psychiatry and psychoanalysis as well. If the works of...phenomenology are ejected from

psychoanalysis and psychiatry, then we are left with a disparaging antithesis of the human condition. Nowadays psychoanalysts are ignorant of physiology, medicine and phenomenology. Freud did not hope for this; on the contrary! ... If we ignore these foundations – phenomenology, neurology, physiology – we are accomplices in segregation’ (Reggio, 2007)p38.

Psychoanalysis in its radical reconstruction of the human condition attributes repetitions to internalised unconscious constructions. It recognises that much of the meaning that occurs in speech is unconsciously transmitted, and untapped by standard research. Psychoanalysis differs to other methods of research as it explains group and organisational behaviour ‘in terms of what is going on inside the psyche of each individual’ (DeBoard, 2005)p24.

Objects and subjects present themselves as something denoted by reference to time and context, including the perceiver’s psychical state in which they are experienced. The psychoanalytic approach allows for objects and subjects to present as outside of a framework which denotes them as something that can be defined and described whereby something can be experienced but not categorised as it occurs outside the symbolic and within the real. Psychoanalysis relegates consciousness, particularly in relation to desire, motivation and orientation to the world, as contributing only a small part to our relationship with it. Psychoanalysis is concerned with the organisation-in-experience.

‘The dynamics of such organisational experience are focused and refined by attention to role performance’ (Long, 1997)p3.

Psychoanalysis takes a pragmatic and inclusive position in relation to the suspension of presupposition arguing for the critical examination of the researcher’s customary ways of knowing. There is a shift from the researcher’s contemplation about phenomenon to an attempt to explore phenomenon from inside the participant experience based on their description of it. Psychoanalysis does not hold the belief that it can emphatically experience the world as the subject does rather the contention that actions have meaning and the analysis progresses as these meanings are brought from the unconscious into consciousness (Fink, 2007).

‘Freud’s hypothesis relative to the unconscious presupposes that, whether it be healthy or sick, normal or morbid, human action has a hidden meaning that one can have access to. ...’ It is the minimal position that is fortunately not too obscured in the common notion of psychoanalysis: in what goes on at the level of lived experience there is a deeper meaning that guides that experience, and one can have access to it. Moreover things cannot be the same when the two layers are separated’ (Lacan, 1959-1960)p312.

‘Psychoanalysis has largely conceded that interpretation is an art and not a science and therefore psychoanalysts have been prepared to theorise issues like intuition, use of the analyst’s subjectivity, the role of emotion in thinking and the use of unconscious dynamics as a tool for knowledge’ (Hollway, 2007)p78.

The quest in psychoanalytic research is for this deeper meaning and the outcome is suggestive of an irreversible change.

Arguable the hermeneutic circle is a search for deeper meaning however hermeneutics will only carry the psychoanalyst so far.

‘We might say that analysis is a search for meaning that takes place entirely differently than hermeneutics. By bringing in the Real as referent for language, we will see how psychoanalysis makes absence, non-knowledge, the void, a function in the interpretation of meaning’ (Watson, 2004)p118.

Watson (2004) argues that the understanding aimed at by the hermeneutic is the hallmark of error for the psychoanalyst who has to suspend all understanding. Hermeneutics tries to place meaning in language, psychoanalysis places meaning in lack, at the limitation of language.

‘A modern hermeneutics would have to be based on the impossibility to signify, which is precisely where psychoanalysis dwells’ (Watson, 2004)p120.

An impossibility to signify widens the gulf between psychoanalysis and modern science which is all about the need to signify, quantify and account without recognising that the only place we can access meaning is at a limit point. Meaning emerges from the impossibility, the limit of signification from a paradox where words fail and actions give us an account. Modern science fails by an error in belief, an illusion that everything can be understood and said. Indicating for psychoanalytic research not just speech but gaps, lacks and actions of the subject require analysis.

5.6.2 Floating attention

Menzies Lyth (Menzies Lyth, 1989) exposed some of the requirements needed in a psychoanalytic researcher, the ability to recognise and analyse content and dynamic. Fenichel's (Fenichel (1946) cited in Menzies Lyth, 1989) holds that from a psychodynamic perspective that institutions are shaped by and shape the individual.

Freud cautions against concentrating attention to such an extent that it leads to a bias where the researcher;

‘Begins to select from the material before him, one point will be fixed in his mind with particular clearness and some other will be correspondingly disregarded, and in making this selection he will be following his expectations or inclinations. This however is precisely what must not be done, ‘in making the selection, if he follows his expectations he is danger of never finding anything but what he already knows’ (Freud, 1912)p112.

Fink (Fink, 2007) supports Freud's noting that the experienced analyst is always surprised by what he finds and follows the recommendation that each case is approached as if it is our first therefore we should presume nothing about what will be revealed (Fink, 2007)p10. This process allows the analyst/researcher to hear what is new and different in what the participant says as opposed to hearing just what we want or expect in advance to hear (Fink, 2007)p10.

5.6.3 Free association and floating attention

For an analysis to progress parallel processes, free association and floating attention, are required to enable the transition in the unfolding speech of the analysand from empty to full. Free association is achieved by allowing the analysand to speak without a demand from the analyst for an agenda. The full speech that emerges is constructed with signifiers shifting the concern to the signifier and signified.

‘Free associations defy narrative conventions and enable the analyst to pick up on incoherence's (for example, contradictions, elisions, avoidances) and accord them due significance’ (Hollway, 2007)p37.

The question that emerges is the language of the analysand. Signifiers have independent/individual meaning and no central lexicon can be used to interpret their meaning making the work appear onerous and impossible. By applying

psychoanalytic group psychology sense can be made from the utterances of members when the researcher identifies repetitions and patterns relating to work culture analysis. Of importance is the analyst ability to listen to the quality and texture of speech and be receptive to hearing when the analysand shifts from speaking about what is conscious to unconscious material. Initially the analysand is instructed to speak freely saying anything and everything that comes to mind, to hold nothing back. This instruction to free associate is a challenge for the analysand bound in social rules of what can and cannot be said, what is acceptable, there is an experience of alienation; the unconscious is alien to us.

The analysand speaks to a relatively silent subject supposed to know, however the silence of the analyst is a paradox. This process is disconcerting and unpredictable for the analysand, in the manner that the unconscious is unpredictable. The unpredictable quality of the encounter enables the unconscious to emerge and disappear often before the analysand recognises it. It is heard by the analyst providing opportunity for interpretation to the unsuspecting analysand.

Floating attention is not a process where the analyst picks on one statement and tries to make sense of it or connect it to other things. It is instead a process of allowing attention to float between statements, attempting not to make conclusions or connect them together appearing to be quite the opposite of what a diligent researcher would do. Fink (Fink, 2007) draws attention to Lacan's (2006) directive that by becoming obsessed with trying to find meaning in the analysand's story we can fail to listen to how it is told, we miss the words used the subjects expressions, slips and slurs (Fink, 2007)p11. So when a participant includes in his speech a 'for example' a 'by the way' or 'on the one hand' and goes on to tell a story what needs to be followed up is what 'other example', 'what other way' or 'on the other hand', was not recalled and told.

Floating attention requires practice; the analyst must;

'Wean themselves for listening in a conventional way and realise that it is often of far less importance to understand the story or point than it is to hear the way in which it is delivered. Free floating attention is a practice – indeed a discipline - designed to teach us to hear without understanding' (Fink, 2007)p12.

This is a distinct shift away from the traditional approach to research where the quest for understanding is the holy grail of the process.

Observation, interviews and in-depth exploration of interview texts are described by several researchers (Bicknell, 2005, Long, 1997, Comerford, 2010, Erlich-Ginor, 1998, Burkard, 1999, Hollway, 2007, Vanheule, 2002), as employed in psychoanalytic research. Processes that the psychoanalytic researcher can adopt with the prerequisite that conclusions should be coherent with psychoanalytic practice and theory (Lievrouw, 2003a), analytic discourse and attention to content and dynamic (Menzies Lyth, 1989) ensuring a psychoanalytically meaningful analysis. Clustering speech into themes is replaced by the identification of repetition.

5.7 Language analysis

‘Both hermeneutic interpretations of psychoanalysis and structuralist readings, in turn, reflect a growing concern with language in Western academic life’ (Parker, 1992)p106.

The researcher will privilege the psychoanalytic method of language analysis taking into consideration a number of theorists and Parker’s (2005) argument that a Lacanian analysis emphasis form over content (Parker, 2005a)p167. Heidegger’s later works attempted to capture the concerns Greek philosophers noted about the experience of humans as beings whose activities of gathering and naming are above all a response to what is more than human. Foucault’s (Foucault, 2006) description of medicine as a process of observation and classification is a postmodern understanding of the concern of earlier philosophers.

‘That which resists all human mastery and comprehension. Such terms as ‘nothingness’ ‘earth’ and ‘mystery’ suggest that what is itself to us always depends on a background of what does not show itself, what remains concealed. Language comes to be understood as the medium through which anything, including the human, first becomes accessible and intelligibility. Because language is the source of all intelligibility, Heidegger argues that humans do not speak but rather language speaks us – an idea that becomes central to poststructuralist theories’ (Audi, 1999)p372.

Lacan emphasis that language is imposed upon us by anOther and that the unconscious structured like a language is imposed from an external source simultaneously recognising the impossibility of any consideration of the human condition prior to the inception of language. This acknowledges the gap that exists between what we can say and what we mean but cannot say and even when we describe something we can only understand what it is by recognising what it is not, for example;

‘Man does not become a signifier until woman exists’
(Watson, 2004)p130.

This places language and its limitations in a privileged and central place in this methodology. Additionally Parker (Parker, 1992) argues that the problem with language extends to our interpersonal relationships;

‘The relationship between ourselves and others is fraught because discourse makes contact possible and distances us from what it replaces, that to which it refers’ (Parker, 1992)p108.

Psychoanalysis can be characterised as an approach that takes account of a ‘not all’ (Watson, 2004)p124. This involves not assuming that meaning is out there at some infinitely far-away place or that understanding should be based on unity, it aims for a more ‘proximate infinity and a knowledge based on what is missing’ (Watson, 2004)p124.

‘Psychodynamic orientated organisational researchers explore workers assumptions and attributions that often take the form of defensive projections and distorted images. These projections harm the delivery and content of communication and thus task accomplishment’ (Menzies Lyth, 1989).

Diamond (Diamond, 1993) concurs that the psychodynamics of linguistics and communication is central. Lievrouw (Lievrouw, 2003a) addresses Lacan’s discourse theory as a research tool in that it is a theory that helps us to formalise the positions that a subject takes within discourse.

‘We run around in a language, so to speak, looking for something that is missing’ (Lievrouw, 2003a).

This quest for something that is missing is the quest for meaning, truth and wholeness, resulting from dialectic of recognition. Recognition under-pins the function of language to tell the truth, and the individual's speech reveals his desire for truth, (Parker, 1992)p110. Wittgenstein (1889–1951) argued that the social and interpersonal reality that we experience and live in and through is primarily constructed through language.

‘Sociologists in the 1950’s and 1960’s decided that the way to understand social life was to analyse the micro-strategies that people use in order to manage interpersonal and group encounters’ (McLeod, 2002)p91.

This indicates that alongside the analysis of the language of participants consideration of the social organisation of the group through language is essential.

‘Patterns of discourse in capitalist society hold in place chains of different categories (of class, race and sexuality, for example) and so the analysis of language is also necessarily an analysis of ideology, with ‘discourse’ to be conceptualised here as the organisation of language into certain kinds of social bond’ (Parker, 2005a)p164.

5.8 Summary

Psychoanalytic methodology is concerned with discourse and reflexivity. It shares some similarities with other qualitative research approaches, however there is not an exact match between psychoanalysis and other research approaches due to its uneasy relationship with both science and philosophy and its core research function making the hidden unconscious aspect of the research subject visible.

Within the qualitative paradigm conventional research structures share data collection, management and analysis methods with psychoanalysis with the major exception that psychoanalysis’ concern with the unconscious radically shifts how the analyst as researcher approaches the research process.

‘The unconscious defies rationality and operates at a more symbolic level’ (Crowe, 2004b)p6.

Consequently to this defiance of rationality the investigation of data at the symbolic level becomes an investigation of language, it limits and its meaning that privileges gaps in the symbolic.

The psychoanalytic researcher is required to remain true to an analytic discourse following the prerequisite that conclusions should be coherent with psychoanalytic practice and theory in order for them to be psychoanalytical meaningful. Psychoanalysis is always subjective. Subjectivity is arguable a strength as opposed to a weakness in the methodology as it denotes the position of the researcher and the researched.

This lack of a distinct body of knowledge, outside of psychoanalytic writing, recognising it as a methodology has not inhibited previous researchers from utilising psychoanalysis as a research method, the wealth of their results influenced current conceptualising of mental health (PDM Task Force, 2006).

‘The relative dearth of a research agenda within psychoanalysis has derived in part out of the field’s collective mistrust of manualization and research tools’ (Busch, 2010)p308.

However the shift towards quantitative conceptualisation of so-called mental illness has contributed to the dearth of extensive coherent psychoanalytic research methodology accounts. This lack in describing the research process could be understood as a defensive position arising from the psychoanalytic community’s uncomfortable relationship with science or more plausibly, the almost indistinguishable quality of psychoanalysis as treatment or theory from psychoanalysis as research alongside the recognition that a fully articulated research methodology for psychoanalysis runs the risk of becoming a metadiscourse. Consequently few psychoanalysts have described in detail methodology in contexts outside of the therapeutic encounter. This defence carries little weight outside the psychoanalytic community and is understood as a gap in psychoanalysis in providing methodological evidence for the claims it makes.

The concern with subjective experience in psychoanalytic methodology provides an evocative narrative derived from empirical data that fills the gap in the subject’s

understanding by translating what is unconscious into consciousness in tandem with an unconscious re-jigging of the subject's understanding of life. Part of the data is the identification and analysis of gaps and lapses which retains the link to existing practice and theory. The evidence psychoanalysis supplies, its theories are judged on how well they fit with existing psychoanalytic theory and the subject's experience, metaphoric approximations of unconscious experience. There is sufficient evidence for the unconscious, its actions can be evidenced to provide a rich description of inter and intrapersonal experience.

‘When we speak we are often spoken by discourses, and positioned as subjects in ways we may often try to resist. Our personal relationship to language is tense, contradictory, ambiguous’ (Parker, 1992)p110.

The concept of evocative narrative orientates the psychoanalytic researcher to the primacy of language. Working with the principle that language is critical, psychoanalytic research;

‘is not psychoanalysis in the sense of a discipline the assumes the existence of stable, casual mental structures than can be known through interpretative practices much less as a form of analysis ‘inclined towards the adaptation of the individual to the social environment’ (Lacan, 1993a),

rather it is a return to the more challenging aspect of psychoanalysis that have inspired critical theorists (Bicknell, 2005)p2 the quest for truth. Psychoanalysis provides a dialectic of recognition as speech reveals the desire for truth.

The philosophy of psychoanalysis is a philosophy of mind expounding the belief that the unconscious influences actions. Neuroanalytic theory supports the emphasis placed on language by contemporary psychoanalysis and provides additional support for the unique unconscious relationship between the subject and signifiers (Peled, 2008). Psychoanalysis, science and philosophy share the aims of finding truth and meaning, however psychoanalysis place truth in the speech of the subject rather than in the accumulation of knowledge. The psychoanalytic approach allows for objects and subjects to present as outside of a framework which denotes them as something that can be defined and described recognising that something can be experienced but

not categorised as it occurs outside the Symbolic and within the Real creating a caution about sense making managed through the process of floating attention.

Floating attention allows attention to float between statements, attempting not to make conclusions or connect them together in some manner or becoming obsessed with trying to find meaning, phenomenological theme chasing, in the participant's story. The emphasis is on how the story is told and what needs to be followed up. This is an acknowledgement of the gap between what we say and what we mean but cannot say and how we understand what it is by recognising what it is not. This places the gaps in language in a privileged position which takes into account the 'not all', that an understanding can be discovered in what is missing from the words and actions of participants. This is achieved by descriptions and analysis of the dynamics underlying discourses which are concerned with relationships, symbolically maintained relationships which contain particular distortions which have to be unravelled in the process of analysis.

Psychoanalysis as a research methodology has accumulated a rich body of knowledge in relation to the social organisation of groups. As participants are recognised as unconsciously influenced by the group their utterances and actions are a reflection of a social bond. Patterns of relationships and individual perceptions of organisational experience portray the identity of the organisation. The history of the organisation in relation to critical incidents and events as described by participants and observed by the researcher become a significant part of data that the methodology captures. The social institution, an external reality, is explored in relation to patterns of behaviour and how it affects the structure of the individual through an analysis of role structure and work culture with a particular emphasis on attitudes, beliefs, patterns of relationships, traditions, the psychosocial context in which the work is conducted and collaborative practices. The next chapter provided detailed descriptions of how the psychoanalytic methodology is operationalized as a research method.

Chapter 6 Operationalizing psychoanalytic research

This chapter presents an account of the research process employed. Five data sources were combined to generate the research finding. Data was collected by a targeted literature review, on-site non-participant observation which generated field notes, informal and formal interviews which generated audio recordings, transcripts and the researcher's reflections. Quiet presence and free floating attention, techniques of psychoanalysis, featured as guiding principles for the researcher's conduct. The amassed data was subjected to a psychoanalytic investigation with reference to the speech and actions of participants. Freud (Freud, 1937b) outlines specific instructions for conducting the clinical work of psychoanalysis to enable the emergence of transference and subsequently manage it so the analysand can progress in making what is unconscious conscious; these instructions are presented in a linear order here for purposes of description, however in a clinical setting they would be operationalized subject to the patient's progress. Similar to Bicknell and Liefoghe (Bicknell, 2005) this study does not involve the psychoanalysis of subjects, instead it views accounts through a lens informed by specific aspects of psychoanalysis (Bicknell, 2005)p9. The method is summarised in the chart below.

Table 2 Summary of Data collection and analysis method

Data Source	Data Management	Data Generated	Analysis techniques	Combined Analysis
Literature	Literature Search, Reading	Written Notes	Critical appraisal in relation to the merits of individual texts	Combination of all data sources using a psychoanalytic lens to identify, describe, analyse and generate psychoanalytic formulations
Field Work				
Site Visits	Observation in clinical settings	Field notes	Psychoanalytic appraisal of the totality of each site visit	
Informal Interviews (Opportunistic spontaneous conversation)	Quite presence and free floating attention	Field notes which included verbatim quotes when possible	Psychoanalytic listening utilising floating attention to identification of themes	
Formal Interviews	Planned formal semi-structured interviews	Audio recordings, written notes and transcripts	Psychoanalytic listening utilising floating attention to identification of themes, language, lapses and gaps	
Position of researcher / reflexivity	Reflective notes and diary	Written accounts of researcher's experience and the supervision process	Personal reflection informed by psychoanalytic training and theory to explores and identify reactions to the data and the role of researcher	

6.1 The research setting

This study site was chosen as it provides mental health care for an expanding catchment area of 222,049 people¹¹ and is typical in size and structure of catchment areas in the Irish mental health services. This setting also provided care to people from both rural and urban settings which captured the typical spread of the Irish population. Additionally the chosen study site has featured in both print and TV media as an exemplifier of the organisation of mental health care in Ireland around an institutional structure (Gilesnan, 2005a, Connolly, 1980). Most significantly the literature indicated that the constituting nature of the institution influences the dynamic, the transference between individuals suggesting that change is unlikely to occur without recognition of the impact of the unconscious (Fenichel (1946) cited in Menzies Lyth, 1989, Menzies Lyth, 1988). Change was imposed on the service at intervals of seven and two years prior to commencing the study with the introduction of new mental health legislation (Government of Ireland, 2001a) and policy (Government of Ireland, 2006). These factors combine to test the argument that regardless of the level of reform at a national level little or no real change occurs locally due to the impact of the unconscious life of an organisation. Two settings within the study site were used for data collection, the acute admission units, including their associated therapy centre, comprising of 48 beds located in a single store building in the hospital campus and a day hospital located in a residential urban area. The settings managed by the HSE provided daily accommodation and services for about 100 people (patients, clients, staff, visitors and researchers).

6.1.1 Gaining access

Gaining access required negotiation over a period of six months. Commencing in December 2007 the researcher had a series of meetings with the Clinical Director, Director of Nursing (DON) and Service Administrator. Subsequently and on provision of the University ethical approval the service management team granted written approval to proceed. Permission was sought for access to the acute admission units and a day hospital. The DON issued a memorandum to the identified settings informing them that permission to conduct research had been granted. Clinical Nurse Managers (CNM) was contacted and meetings arranged to discuss the research. All

¹¹ The number of people registered as resident in the catchment area during the data collection period (August 2008-August 2009)

site visits including the initial meetings with CNM's were treated as data collection opportunities.

6.1.2 Site visits

Site visits were conducted during normal office hours, (08.00–18.00) as this reflected operational times for the day service when all grades of staff contribute to service delivery and excluded official visiting times in the admission unit. Between 18.00 and 08.00 data collection would more likely reflect the immediate social world of a limited group not the total population at which the study was aimed. The decision to confine site visits to a specific period of the day potential resulted in the exclusion of additional relevant data.

To capture the total situation participants were observed in the real life context of services. Mental health services are places of observation where observation by strangers is normally expected therefore overt observations in the Admission Unit was conducted in general ward areas, corridors, hallways, sitting rooms, dining room, bedrooms, meeting rooms, the therapy centre and offices. Observation in the Day Hospital was conducted in hallways, offices, corridors, meeting rooms and in the unit's craft room. Unrestricted access was granted; however the researcher did not enter any area without seeking the permission of people occupying them, access was never denied.

6.1.3 Recruitment and sampling

The study site provided services for male and female adult patients therefore the inclusion criteria included male and female participants from the general acute mental health services aged 18-65 years. Patients less than 18 years of age or over 65 years of age attend specialist mental health services¹². This was modified to specific criteria for interviews that participants were willing and able to give informed consent (Hollway, 2007). The planned exclusion criteria was participants aged less than 18 or more than 65 and people attending services deemed by staff or the researcher as unable to give informed consent due to their health status. It was anticipated that this

¹² Patients under 18 years of age are entitled to attend adolescent mental health services however these services are not available in early catchment area. Patients over 65 years of age are entitled to attend Psychiatry of old age services, however there are regional differences in how these services are administered; in some catchment areas only patients aged 65 and over presenting for the first time are entitled to avail of this specialist service.

subjective exclusion criterion would only apply to a small number of participants. In practice the inclusion and exclusion criteria were problematic. Patients over the age of 65 occupied services, as specific services for this group had been relocated to the admission unit in the period between planning the study and commencing data collection, additionally the lack of an adolescent service created potential for the presence of patients under eighteen years of age. Discretion judgment and consultation with staff were used to include and exclude participants who did not appear to meet the inclusion criteria.

6.1.4 Sample size

Small sample size is a frequent criticism as the data lacks generalizability and the study may be un-reproducible as it is context specific. This perceived weakness is also its strength provided it is appropriate for the question being asked. The observable homogenous nature of social institutions (Reggio, 2007) allows latitude in the application and comparison of qualitative results across sites. However psychoanalysts and qualitative researchers usually remain concerned with subjective experience keeping their focus on the individual, a particular group or specific situation and do not seek nomothetic generalisations. If there is a desire to uncover generalizable findings, which is rarely the case in a contemporary psychoanalytic approach, the aim is towards idiographic generalisations, generalisations from and related to specific cases (Sandelowski, 1997). For example this study aims to understand the management of transference in the mental health services. Transference has been described above as having a universal quality (section 3.1.2); however the aim is to understand how transference is mediated in a particular case. It is the examination of a total situation, meaning the total situation of a particular setting. Remaining with Reggio (2004) argument that social institutions have a homogenous quality it is possible to posit an idiographic generalisation;

‘Generalisation drawn from purposeful samples who have experience of the ‘case’ and thus applicable to similar ‘cases’, questions, and problems irrespective of the similarity between the demographic group’ (Morse, 1999).

For example in the case of hospital services Menzies Lyth (1988), Main (1957), Martin (1992) and Cameron (2005) make no claim for generalizability yet their work in specific settings bears a close resemblance to hospital services elsewhere.

‘Much psychological research depends on the samples selected primarily because they are convenient for the researcher to obtain’ (Howitt, 2005)p35.

‘There is no limit on sample size in qualitative research, time and resource constraints make larger samples impractical’ (Brown, 2001)p351.

The total potential sample size is suggested as a census would have been required at each visit to accurately record numbers. The inpatient facility comprised forty beds and usually had full occupancy; thirty full, part-time and sessional staff provided services therefore the observational aspect included data from some but not all potential participants. Sample sizes for outpatient facilities were also difficult to predict as the staff compliment and patient attendances varied daily between ten and thirty depending on planned activities. In identifying sample size the researcher listed participants observed at each data collection session in field notes.

It was anticipated that up to twenty interviews, (formal and informal), were required to support the other data sources. This is in keeping with sample sizes obtained for similar and related studies (Menzies Lyth, 1988, Menzies Lyth, 1989, Main, 1957, Bion, 1990, Scheper-Hughes, 2001, Estroff, 1985). The anticipated sample size was flexible allowing for saturation and deemed appropriate for a qualitative study and the subgroups of participants (McLeod, 2002). The researcher adopted a position of seeking quality based on Schacter’s (2012) principle that the strong point of qualitative research is that it catches material that cannot easily be represented numerically. ‘

‘In other words never mind, the width feel the quality!’ (Schacter, 2012).

In practice the researcher found that the periods of observation allowed for the recording of a much greater volume of informal conversations/interviews (n156) than anticipated. The on-going analysis of this data and the field notes supported data from the formal interviews.

Table 3 Summary sample size

Data Source	Number	
Multi-Disciplinary Team (MDT) meetings	6	Data drawn from sets of field notes
Observation in Unit offices	22	
Observations in unit day rooms and activity areas	12	
Observations made in additional settings	12	
informal interviews ¹³	156	
Formal interviews	10	

6.2 Data management

Data were collected and managed in an order commencing with the literature reviewed and followed by observations and interviews. Psychoanalytic research utilises multiple data sources, participants' speech and actions, observations of social and cultural structures, examination of the products of a group or culture, making it an examination of a total situation (Menzies Lyth, 1989, Fotaki, 2010, Lacan, 1960-1961, Vanheule, 2003, Bion, 1990, Diamond, 1993, DeBoard, 2005). Multiple data sources and multiple methods are commonly used in qualitative research to reflect a total situation;

‘It is the formalized multi-method form of ethnographic research that takes it beyond ‘everyday’ sense-making activity into the domain of formal psychological research’ (Taylor, 2006a)p36.

There are four headings under which ethnographic research is conducted which were used to guide observations, but not exclusively as all data was subject to a psychoanalytic gaze.

1. ‘Gathering data from a range of sources, e.g. interviews, conversations, observations, documents
 2. Studying behaviour in everyday context rather than experimental conditions
 3. Using an unstructured approach to data gathering in the early stages, so that key issues can emerge gradually through analysis;
 4. Comprising an in-depth study of one or two situations’
- (Taylor, 2006a)p36.

¹³ The number of informal interviews, conversations that occurred during all of the data collection phase is a conservative estimate of informal conversations, 3-4 during each site visit, indicates a minimum of 156 encounters of this nature.

6.2.1 Data collection and saturation

Psychoanalysis requires an immersion in the day-to-day experience of the analysand by the analyst ideally working with the analysand two to six times a week, with the explicit purpose of enabling the analyst to keep pace with the analysand's daily life and to avoid being side tracked or losing contact with the present (Freud, 1937a). For observations to be meaningful the researcher is required to immerse themselves in the setting, essentially developing a pattern of regular attendance at the site to keep pace with the day to day life of the participants. Long term observation conducted as a series of studies over several decades can yield information not available in any other way. Estroff (1985) spent two years collecting data, Menzies Lyth (Menzies Lyth, 1988) spent three months gathering data on the mental health services at Epsom. Bernard (Bernard, 1988) states that applied research, conducted over periods of one to three months, can yield reliable results on sensitive topics particularly when the researcher already speaks the language and if they have previously worked with the people or the organisation that is the subject of study. Psychoanalytic research involves seeking sufficient data for saturation, providing a balanced picture mindful of repetitions; researchers repeatedly search for new data until a level of certainty can be achieved confirming what has been discovered while acknowledging that single events are not necessarily the norm of daily activity (Hollway, 2007). Operating from Bernard's (Bernard, 1988) principles of speaking the language and having previous work experience with the population and Menzies Lyth (Menzies Lyth, 1988) technique the intention was to conduct the field work over a period of six to nine months, this extended to twelve.

Psychoanalysis is of indeterminable length. There are no hard and fast rules available at the start of an analysis that determines when the process will be complete (Freud, 1937a) as it depends on the ability of the analysand to work through their unconscious material. Freud (Freud, 1937b) proposes that analysis commences with a trial period to allow for an initial assessment and the establishment of therapeutic alliance an important period which establishes the transference. Time management in qualitative research follows a similar pattern. Therapeutically psychoanalysis does not restrict itself to a timeframe as the analyst remains committed to the analysis for whatever period the analysand requires to complete the work as a committed qualitative

researcher collects data until saturation occurs. Data collection commenced in August 2008 and was completed in August 2009. After repeat visits, interviews and initial analysis repetition in service occupant's speech and actions was observed indicating saturation had occurred (Beins, 2004). During month nine the researcher decided to complete data collection during the following three months using this period to confirm findings while allowing for additional data to emerge as each session in psychoanalysis is approached with the possibility that new material will be discovered.

6.2.2 Literature as data

Reviewed literature created a critical summary placing the research questions in context by identifying gaps and weaknesses critiquing, supporting and justifying the investigation. The advantage of this approach is that it allows a level of confidence regarding what is already known in the field and the additional findings from this study will potentially extend the previous knowledge and theory and possibly influence future research activity (Beins, 2004). Literature served the purposes of being a source of research ideas, orientating the researcher and providing conceptual and contextual information (Hollway, 2007, Howitt, 2005, Diamond, 1993, Beins, 2004, McLeod, 2002). To avoid the inherent risks that under or over refinement results in the non-inclusion of significant texts research supervision, consultation, on-going curiosity and willingness to read in relation to the subject throughout the research period was maintained.

6.2.3 Recording data

For consistency all data was transferred onto a standard field note template included indices of time, place and social circumstances (Appendix B), the process of transcription is opportunistic for data integration and analysis. While consistency is important and used as an expression of validity there are inherent risks that valuable information can be misrepresented or lost in the process of translation from one medium to another. Original notes and recording were retained and referred to as transcripts were reviewed to ensure accuracy.

6.2.4 Field notes

‘Field notes consist of relative concrete descriptions of social process and their contexts, which sometimes have to be written up out of the immediate situation if it is clear that note taking would be an intrusive activity’ (Taylor, 2006a)p40.

Being mindful of reflexivity and the desire to maintain quiet presence notes taken on site were recorded in notebooks and written up immediately after leaving the site. A table of abbreviations was developed to account for different environments and participants encountered (Appendix C). The abbreviation table was modified for data presentation to protect the identity of participants. All participants are identified by a code; e.g. Participant Number one = PN1, Participant Number two = PN2 and so on. This was deemed appropriate to reduce identifiability, reflect the translation from individual to group psychology, and enable reading of the text as a presentation of the total setting as opposed to an examination of subgroups/individuals within the social situation. Quotations from field notes, which include participant speech, occasionally include biographical work role information to establish essential context. A similar system of coding was adopted for the field notes linking them to the order in which they were recorded; e.g. FN1 = Field notes one.

An exception was used when attending MDT meetings, where notes were recorded in the presence of participants. MDT meetings varied in duration between 45 minutes and two hours generating more data than could be retained accurately without notes. If the researcher had opted to remove himself at intervals for note making it would have potentially disturbed participants, valid data may have been missed, quite presence not maintained.

6.2.5 Data analysis

The process of data analysis adhered to the principles of the psychoanalytic interview as described by Freud in his Papers on Technique (Freud, 1911-1915). The key feature of a psychoanalytic approach to data analysis relates to the position of the analyst. The analyst is required to remain true to an analytic discourse to sustain

his/her position. However the psychoanalytic researcher is also required to address the Other via a Hysterical Discourse (section 2.5.3). The Hysteric is the one who asks a question and is persistent in their demand for an answer, consequently hysterics make good researchers. Analysis was managed as follows;

1. Adherence to the principle of floating attention (section 5.6.2) on the initial encounter with the data.
2. Subsequent encounters with the data involved the development of themes which were grouped to construct the psychoanalytic formulations under which the data is presented.
3. The speech and actions of the participants was treated as the primary data source, however it was analysed with a theoretical understanding and theory of the subject in mind (Kvale, 2009, Hollway, 2007). The theoretical understanding and theory of the subject relate to a belief in the unconscious and its influence on lived experience as described in chapter 2.
4. The analysis involved looking for key routes to the unconscious in the speech and actions of participants, in particular the elements of metaphor and metonymy were considered (sections 5.6, 5.6.1, & 5.7). Consequently lapsus or gaps in the narrative, difficulty with finding language within a narrative, description of events that were understood as service symptoms, and the metaphors used by participants were given consideration (sections 2.4 on Lacan's Structural framework and Section 2.5 on Discourse which guided this aspect of analysis).
5. As the research question, study aim and fundamental feature of psychoanalysis relates to transference management data analysis included a consideration of participants narratives about Others in the service and the observations concentrated on the nature, content and style of subject-Other relationships between participants (Chapter 4 presents detail on working with and through transference).

Data analysis were an on-going circular process requiring multiple revisions; analysis commenced during data collection and were aided by keeping reflective notes which enabled secondary extensive analysis and reflection. Kvale and Brinkman (2009) describe three different interpretational contexts;

‘Self-understanding, a critical common-sense understanding and a theoretical understanding’ (Kvale, 2009)p214.

Self-understanding is validated by the participant, critical common-sense by the general public and theoretical by the research community - peer validation. The adopted approach psychoanalytic interpretation exceeds self and common-sense understanding.

‘For extensive interpretation of meaning, rich and nuanced descriptions in the interviews are advantageous, as are critical interpretive questions during the interview’ (Kvale, 2009).

This necessitates detailed verbatim descriptions. However, Hollway and Jefferson (2007) argue that the commitment in social science research to representing interviewees voices can eliminates distinctions between description and theoretical interpretation (Hollway, 2007)p59, emphasising the need to analyse the data with a theory of the subject, this includes reflexivity to assist in the analysis.

‘Using reflexivity is not a substitute for utilising theory it can strengthen a theoretical conviction’ (Hollway, 2007)p67.

Second stage analyses lead to the emergence of threads of information and recognition of commonalities in participant’s perceptions which were added to the texts. This process of additions to the text differs to coding which is frequently used for the management of ‘a mass of unstructured data’ (Hollway, 2007)p68. By making additions to the text the researcher is enabled to understand the data in relation to a total situation.

‘The structuralist movement, which started in social anthropology and linguistics, emphasis that meaning could only be understood in relation to a larger whole, whether it be the culture, the sentence or the narrative’ (Hollway, 2007)p69.

Hollway and Jefferson (2007) recommend using a proforma of categories to aid this process; the researcher used the field note template to record additions to the text which consisted of comments on themes and ideas that emerged.

A third phase of analysis was conducted; transcripts were reread with identified threads, commonalities and reflections in mind. This repetitive process of reading rereading and condensing data into coherent threads allowed for immersion in the data and the identification of connections between the different data sources in a bottom-up approach. Similar to Hollway and Jefferson (Hollway, 2007)p74 approach five elements of the data were drawn together which resulted in the emergence of psychoanalytic formulations;

1. Verifiable information in the interview transcripts (e.g. references to external sources, job titles, service structures).
2. The free associations of interviewees (what they said when left to give unstructured narratives).
3. Shared cultural assumptions of the interviewer and interviewees (e.g. nurses are usually female and doctors are usually male).
4. Sociological knowledge (from the literature reviewed and the researcher's experience).
5. Psychoanalytic knowledge (from the literature reviewed and the researcher's experience).

All stages required mindfulness of subjectivity, however this third stage required extra vigilance to ensure that in manipulating the data the researcher remained inclusive of all data related to the research question and true to psychoanalytic discourse in generating findings. In psychoanalysis the analyst is slow to offer early interpretations, such offers are normally rejected. The initial task is to engage the analysand in the therapeutic process and then enable an effective transference. The more profound the rejection of an interpretation the more likely it is to have been true for the analysand, early interpretations risk nullifying therapeutic effect and can result in the premature termination of analysis. Researchers are required to take a similar position, it is inappropriate to draw conclusions early in the process or even suggest to participants potential conclusions as they potentially bias the information participants disclose. Psychoanalysts hold that analysand needs to be close to discovering their own solutions before interpretations are revealed. When the analysand has succeeded in bringing into consciousness the unconscious repressed material they are in a position to verify their discoveries against external reality.

‘Psychoanalytic studies, and also psychological interview investigations have often involved an individualistic and idealistic focus on the intentions and experiences of individuals. There has been a neglect of the social and material context that the person lives in. The interview method as such does not, however, need to neglect the social and economic aspect of the human situation’ (Kvale, 2009)p213.

Care was taken in the data analysis to compare the interview data with the external reality observed beside statutory structures.

‘Just because we claim that both patient and analyst play a substantial role in constructing what they agree to be true, we need not deny that reality itself has its own structure apart from that which we impose on it’ (Aron, 1996).

6.2.6 Presenting data

Research reports do not aim for dramatic pace despite the requirement that the material provides an evocative account and ‘plausible suggestions as to what may underlay a situation’ (Parker, 1992)p111. Psychoanalysis in its pursuit of the truth does not base its cure on merely educating the patient, as knowledge alone rarely enough reduces resistance. In psychoanalysis the analysand is enabled to combine knowing (conscious knowledge) with not knowing (the unconscious). Initially the analysand is enabled to become aware of what is repressed which allows a connection with the place where the repressed recollection was contained. When conscious thoughts reach the point in the unconscious where they are connected change is enabled, consequently an action research approach was deemed unsuitable. In psychoanalytic research of a social situation what is required is a final report that links the knowledge derived to particular points in the site where change is required.

‘At the heart of the anthropological method is the practice of witnessing, which requires an engaged immersion over time in the lived worlds of our anthropological subjects. Like poetry, ethnography is an act of translation and the kind of ‘truth’ that it produces is necessarily deeply subjective, resulting from the collision between two worlds and two cultures’ (Scheper-Hughes, 2001)p318.

By combining the psychoanalytic position on truth, the lifting of repression, bringing the unconscious into consciousness with the subjective approach favoured by the ethnographer it is possible to deliver a report that resonate with participants and

identify areas where changes is required for a more workable future. While some theorists argue against any alignment between psychoanalysis and ethnography Davis (Davis, 2003) suggest a hybrid methodology in which ethnographic analysis leads to direct engagement with psychoanalytic theory, rather than to a rejection of it. This position aims to bridge a gap between two fields that complement each other. Ethnography reinforces demographic categories of identity and psychoanalysis reinforces unconscious identification. Davis (Davis, 2003) claims to have found;

‘Evidence to corroborate a postmodern understanding of identity as mutable, ambivalent, and multiple rather than static and unitary arguing in favour of not adopting psychoanalytic ideas wholesale as a master key decoder, rather than testing their application at particular moments of cultural articulation’ (Davis, 2003)(Davis, 2003)(Davis, 2003)(Davis, 2003)(Davis, 2003)(Davis, 2003)(Davis, 2003)(Davis, 2003)(Davis, 2003)(Davis, 2003)p10.

My position inverts Davis’ approach by adopting psychoanalytic ideas to decode the data, not via a Master but via an Analytic discourse that allows for their verification against external reality akin to the observations of the ethnographer. Ethnographic work can thus be an important method of delivering data for more nuanced analysis about subject-Other relationships.

Studies resulting from observation ‘are often embedded in and constituted by their style’ (Taylor, 2006a)p45. Verbatim quotes allow the reader to engage with participant’s rich narrative. Freud’s, case histories intermingle narrative and analysis giving a feel for the process, Anna O’s description of psychoanalysis as ‘a talking cure’ is much quoted. Freud (Breuer, 1893b)p30 presents verbatim quotes embedded in section on theory, a narrative which is descriptive and instructive in style while referencing technique and theory, the emphasis is on theme and illustration. Taylor (2006) suggests rather than simply ‘telling the story’ as events progress;

‘Another approach would be to write it up in terms of the developmental cycle of the actors or the setting’ (Taylor, 2006b)p46,

Freud’s cases describe the progression of an analysis, the developmental cycle. Lacan offers an alternative style described as ‘original and provocative’ (Daly, 1999) and is understood as;

‘A notoriously difficult writer who loves witty epigrams, puns, drawn out metaphors, recondite allusions, baroque disquisitions and paradoxical pronouncement’ (Rabate, 2003)pxiv.

This provokes challenges and presents a rich narrative mimicking psychoanalysis. We experience the unconscious defying rationality, operating symbolically, we see its actions through description of inter and intrapersonal behaviour, an evocative narrative filling gaps in understanding.

Freud (Freud, 1937b) identifies the suffering of the analysand and their desire to be cured as the motivating force in therapy. Beside this is the secondary gain achieved in illness that subtracts from the desire for a cure. Desire for cure is insufficient as a single motivational force for recovery due to its lack of direction and energy. Psychoanalysis intervenes with these opposing forces by mobilising the energy available for transference by giving information at appropriate intervals providing a direction towards cure. Transference alone is insufficient to sustain a cure only resulting in a temporary recovery brought about by suggestion. The concern with uncovering the motivational forces of staffs’ energetic investment in working successfully with patients and the contrary desire to maintain the status quo suggests the knowledge generated needs to match with a set of workable recommendations in the final report which enable service providers and users to reduce suffering and shift from the secondary gain maintained by current structures.

6.3 Observation and objectivity

Researching the social world requires a reflexive element which acknowledges and explores the place of the researcher (Hollway, 2007).

‘Observation is a common feature of researching the social and can be broadly categorised as empirical work used in studying people’s lives, human activities, ways of life, and human experience’ (Taylor, 2006b)p1.

‘This draws attention to the researcher being part of the world being studied and to the ways in which the research process constitutes what is being investigated’ (Taylor, 2006b)p3.

The researcher’s identity their relationship with the researched and the process contains elements of interpretation and power that need to be accounted for. The

management of transference in psychoanalysis captures the inter-subjective experience of researcher and researched allowing an argument from a privileged position that observations were conducted in a particular manner that acknowledges the researcher's presence, position, and bias; Psychoanalysis is a process in which both analyst and analysand participate. The analyst takes a position of quite presence, which is an active engagement with the subject, but one which is radically different from other forms of social engagement. Psychoanalytic research occurs with an analyst who is present but not engaged in the social world of the analysand.

Psychoanalysis takes place in a particular space at a particular time for the analysand. Freud found that some patients attempted to engage in conversation outside of this allocation, either before a session commences or followings its closure. This is a shift from the formal work towards social engagement viewed by Freud (Freud, 1917b) as transference resistance. He recommends not engaging in any discussion with the patient outside of the allotted time so that the transference remains an integral part of the work. This principle guided the researcher to remain alert to participant's attempts to engage in conversation separate to the research, all on site encounters were considered potential data for the study.

In psychoanalysis from the onset the analysand should do most of the talking, explanation on the part of the analyst should only be offered as required. This direction is entirely appropriate for observational work where the observer intends not to participate in but to gather data on the unfolding process. It is an appropriate stance for individual interviews, as participants are more likely to disclose unconscious material if encouraged to speak freely with minimal direction (Hollway, 2007).

6.4 Skills

A skill is a special ability or expertise enabling the researcher to perform an activity very well (HarperCollins, 2003)p777, skills are learnt in the field or the researcher can take skills into the field with them. There are a number of identified skills for conducting fieldwork which include learning the language, developing awareness and memory, maintaining naiveté and development of writing skills, (Bernard, 1988)p152-160

To become part of any culture it is necessary to speak the language of its inhabitants as shared language gives access to cultures expressions, symbols, signifiers and their significance. Psychoanalysis is the practice of the symbolic function (Lacan, 1977). Considering the Otherness of language and the distance between articulation and desire raised concern that at least two sets of language needed to be considered; formal clinical language used for observation and categorisation besides colloquial language spoken by service occupants. Additional to this the subjective language used by each individual would normally be accounted for in psychoanalysis suggesting that an analysis of the total situations is not possible. However by taking group psychology into account there is an opportunity to listen for shared unconscious associations.

Building explicit awareness refers to an ability to note small details of life revealing significant things about the organisation of culture and society. Collecting data through multiple sources results in a volume of data required structured methods to build and manage the material. Data were transcribed and kept at hand for frequent review.

‘Meaning emerges from qualitative text from the active engagement of the researcher with the text, from his or her drive to know and understand’ (McLeod, 2002)p141.

Remembering, repeating and working through (Freud, 1914b) a trauma management technique was useful in preventing trauma by data overload and for management and analysis, field notes and reflections acted as an aid memoir. Within each set of notes key words and phrases were highlighted aiding memory as each occasion of review reminded the author of where similar signification and repetitions occurred. By repeatedly reviewing the data repetitions were easier to recall and the process of working through enhanced creating a certain pleasure in remembering. This pleasure in remembering is associated to Freud’s discovery of jokes as a route to the unconscious;

‘The act of remembering is in itself accompanied by a feeling of pleasure of similar origin’ (Freud, 1905b)p122.

The aid memoir' was enhanced by cross referencing and using key words to create 'topicality' where appropriate. Freud used the term topicality in reference to jokes that related to a topical subject but describes it as a process where;

'A single word has transported us, with the economy of a long detour in thought, from the circle of one set of ideas to another' (Freud, 1905b)p123.

This demonstrates the role of single signifiers containing multiple significations.

An analyst cannot anticipate the effect of analysis as he is setting in process a methodology aimed at lifting existing repressions. Researcher's aim to collect data relating to a question while remaining open to possibilities that the material uncovered may or may not provide an answer, the end product is akin to the resolution of an analysis. The requirement to recognise and analyse content and dynamic is a parallel process to maintaining naïveté. Adopted the position that the world is shaped by the self and shapes the self, inclusive of the perspective that institutions are shaped by and shape the individual there is a risk that naïveté would be side-lined in favour of seeking confirming data. By conducting an exhaustive description the possibility of arriving at an understanding of what is observed and analysed is somewhat protected. Assumptions in psychoanalysis are held at bay by floating attention, attempting not to make conclusions or connections until an exhaustive exploration is completed and the avoidance of deliberately concentration on any particular aspect guards against following expectations and inclinations and the risk of only finding what was already know. Maintaining naïveté allows the researcher to be surprised. The psychoanalyst does not seek exhaustive descriptions in the same manner as the researcher, a psychoanalyst's attention is directed at latent content, gaps in the data, what is hidden by the manifest, the exhaustive investigation is less in description of phenomena and more in the analysis of speech and actions.

6.4.1 Quite presence and reaction to the researcher

Maintaining the analytic relationship is the responsibility of the analyst, who may have other skills, by not engaging in treating the analysand for organic conditions that may occur during analysis. Prior to commencing data collection the researcher decided that if occasionally he stepped outside of the observer role and participated in care, for example in an emergency, careful consideration would be given before that

session of data collection was included. In psychoanalytic practice engaging in anything outside of the analytic relationship with the analysand would be subject to examination in supervision the same principle applies to research. In practice no emergency occurred where the researcher's other skills were required.

Quite presence enables observation of and acceptance by participants and implies the researcher is open to making their presence explicit when required. Copies of the permission to conduct the research and the ethical approval were carried on all data collections visits. No copies of the memo outlining the study were observed; only one participant acknowledged seeing and reading it. Introductions were repeated on return visits particularly when new participants were encountered, the researcher was recognisable to participants who acknowledged his presence allowing the observation of activities without repeating explanations.

Psychoanalysis is conducted with the analyst outside the analysand line of vision. Taking a position out of sight, listening in a purposeful manner is a specific purposeful ritual (Nixon, 2005). Freud (1913) offered two reasons for using a couch, firstly that he could not put up with others staring at him and secondly that the analyst is also given over to unconscious thought during analysis and does not want to influence the patient through his facial expression (Freud, 1911-1913)p134. Transference is protected from being mingled with the analysand's associations it remains isolated emerging during the analysis as an acutely defined resistance.

As anticipated and experienced following repeated visits the researcher's presence was considered standard and did not appear to disturb the organisation unduly. Staff openly acknowledged the researcher's presence occasionally informing colleagues of the researcher's purpose, patients showed a number of different responses; female patients were inclined to greet the researcher and enquire about his presence, male patients tended to ignore or at least not comment on his presence. Occasionally female patients acknowledged previously encounters and enquired about study progress.

6.5 Interviews

Potential participants for formal interviews were identified based on the literature reviewed and field observations. Analysis of these sources indicated different grades of staff and patients in particular settings as potential key informants. Group psychology literature (Freud, 1921a, Bion, 1990, DeBoard, 2005), indicated the need to interview participants with limited as well as extensive experience of services in order to gain access to personalised yet contextualized accounts. Following identification of potential participants all requests for patients participation were made through senior third parties as agreed when negotiating ethical permission, staff were approached directly. Formal interviews were conducted onsite in interview rooms, designated for the researcher's use. In line with best practice when conducting interviews, participants were given a participant's information sheet (Appendix D) and asked to sign a consent form (Appendix E) before commencing. To maintain consistency in data management interviews were recorded electronically, transferred to the researcher's password protected computer, identified by a set of codes, listened to repeatedly and transcribed onto field notes templates. Informal interviews (opportunistic conversations) were conducted with all participants who addressed the researcher, indicating an element of self-selection; the researcher was mindful to clarify his status; stating he was conducting a study of services.

6.5.1 Free association in interviews

Managing the dynamic of transference is a critical aspect of psychoanalysis (Freud, 1937b)p101. The analyst must not engage in a process of suggestion where transference is used to generate successful treatment. The researcher must also remain detached so as not to engage in a relationship where participants 'perform' to produce satisfactory answers.

Narrative interviews with open ended non-directive questions which centred on the stories the subjects told were used (Kvale, 2009). The instruction to free associate informed how interviews, both informal and formal were conducted. This technique has been used by other psychoanalytic researchers (Bicknell, 2005, Long, 1997, Hollway, 2007).

‘Despite the significant knowledge production of psychoanalytic therapy, in textbooks of psychology methods, the major method by which psychoanalytic knowledge is obtained - the psychoanalytic interview - is absent. Though generally critical of the speculative and reductionist trends of psychoanalytic theory, philosophers have reflected on the unique nature of the personal interaction in the psychoanalytic interview and its potential for personal change as well as its contributions to knowledge about the human situation’ (Kvale, 2009)p44.

Free association in the clinic involves asking the patient to say whatever comes into their mind;

‘The psychoanalyst is eliciting the kind of narrative that is not structured according to conscious logic, but according to unconscious logic; that is, the associations follow pathways defined by emotional motivations, rather than rational intentions’ (Hollway, 2007)p37.

It may seem inappropriate to suggest that a modification of the instruction to free associate can be developed for research on the bases that participants in single interviews would move from social to therapeutic and beyond into analytic discourse with the researcher however Hollway (2007) and Kvale (1996, 2009) argue that it has merit and that the technique secures access to the participants concerns that would not be accessed using a more traditional method.

‘Psychotherapeutic researchers can in their interviews go further than academic interviewers We may venture that the richness of new knowledge produced by psychoanalytic interviews may in part be due to the psychotherapists ‘ethical licence’ to address human phenomena in ways which normally are out of bounds for academic interview researchers’ (Kvale, 2009)p75.

The researcher followed Freud’s opening direction to new analysand’s;

‘Before I can say anything to you I must know a great deal about you, please tell me what you know about yourself’ (Freud, 1937b).

Interviews commenced by inviting participants to speak to the following core question;

Please talk about your experience of relationships with other people while attending this mental health service

Or

Please talk about your experience of relationships with other people while working in this mental health service

This instruction was met with participants seeking clarification about where to begin, acting as a starting point it allowed participants to search around for something to say and for the researcher to encourage them to speak about their experience of and thoughts on the services inclusive of the relationships they had with others in it. Additional cues were then used to encourage participants to speak freely.

I must know a great deal about the mental health services, please tell me what you know about them?

Tell me what you know about the services; how people develop working relationships, what relationships you believe you have with your colleagues / patients / carers.

Say whatever comes into your mind about these relationships even if you feel averse to doing so.

The psychoanalyst discourages systemic chronological narrative as this is less likely to lead to the disclosure of unconscious material than a free flowing account of anything that comes to mind. The instruction to tell your story as it occurs allows for repetitions and for new and additional material to emerge. A task of the analyst is to enable the analysand to discover the important connections in their seemingly disjointed account. Similarly the psychoanalytic researcher utilising interviews seek through analysis of the narrative, themes, that connect aspect of the story.

‘The interview technique involves not intervening until the interchange is handed back and identifying the themes which are apparent, so as to return to them in the order of their appearance to elicit further detail’ (Hollway, 2007)p40.

The style in which Freud encouraged patients to speak and how he subsequently recorded case histories with only scant regard for the sequence of their histories (Mahony, 2000) implies circularity in interpretation, the relation of parts to the whole, indicating interdependence between the interpretation of individual interviews and the

total data amassed (Audi, 1999). A task of the analyst is to enable unconscious data to emerge from the analysand and to enable the analysand to run around in the data allowing interpretation to take place. This process requires analyst as researcher and analysand as researched to remain active in the process even when it appears daunting or fruitless. The interviewer acknowledges the importance of allowing each story to be finished so rather than seeking clarity and risk cutting across the interviewee's narrative invites him to continue his story wherever it goes with non-committal but interested queues resulting in narratives that are a product of the relationship between the researcher and the participant (Hollway, 2007).

6.6 Ethical Considerations

Presenting data requires due diligence to protect the privacy and dignity of participants. Ethics are more than a set of rules containing researcher's activities as research creates situations which are genuine dilemmas which no amount of rules or regulation could effectively police.

'The four fields of uncertainty, concerning informed consent, confidentiality, consequences, and the researchers role, can be used as a framework when preparing an ethical protocol for a qualitative study, and they can be used as ethical reminders of what to look for in practice when doing interview research' (Kvale, 2009)p76.

A Lacanian analysis of discourse carries with it, then a certain 'ethical position' on which, for example, one speaks not from within a 'metalanguage' but as always reflexively positioned in relation to the text' (Parker, 2005a)p175. Lacan held the position that no metalanguage can be spoken which firmly places the researcher/analyst in the chain of signification with the researched. Five general principles underpin ethical standards;

'Beneficence and nonmaleficence, fidelity and responsibility, integrity – accuracy, honest and truthfulness, justice, respect for people's rights and dignity' (Howitt, 2005)p100.

6.6.1 Management of Beneficence and Nonmaleficence

Beneficence is the responsibility to do good; act in the best interest of the participant and ensure that the research is of sufficient quality that it will inform practice.

Nonmaleficence is a commitment on the part of the researcher to avoid harm to participants. Operation from the Lacanian principle that ethics in psychoanalysis are judged retrospectively on the outcome experienced beneficence in terms of research outcomes cannot be judged at this stage, however the researcher is confident that his conduct while collecting data was always appropriate and respectful to all participants. The researcher's commitment to nonmaleficence was managed during data collection by being attentive to participants privacy and confidentiality alongside a commitment to being an attentive researcher seeking a fully and frank picture of the research setting, this extended into managing the data in an open transparent and tireless manner ensuring that the researcher's abilities were utilised fully.

6.6.2 Management of Fidelity and Responsibility

Fidelity implies that the researcher takes responsibility for their actions, adheres to professional standards making their role and obligations clear. The researcher adhered to the ethical permission granted by the University and the subsequent permission from the study site to conduct the research (Appendix F) the code of ethics relevant to his clinical practice, Association of Psychoanalytic Psychotherapy Ireland (APPI) ethic for practitioners (The Association for Psychoanalysis and Psychotherapy in Ireland, 2008, APPI, 1999) (Appendix G) and An bord Altranis guidance to nurses regarding ethical research conduct (An Bord Altranis, 2007).

6.6.3 Management of Integrity, Accuracy, Honesty and Truthfulness

Integrity, accuracy, honesty and truthfulness relate to aspects of research and clinical work particularly if 'the ratio of benefit to harm of using deception is large' (Howitt, 2005)p101. A ratio of benefit to harm allows for some latitude and is manifest in Lacan's (1959-1960) seminar on ethics suggesting that psychoanalysis offers something that is presented as a measure of our action indicating retrospective judgement on process. Researcher's actions (Scheper-Hughes, 2001) are not always judged positively when reviewed retrospectively by participants. Maintaining quiet presence is open to question as this position allowed the researcher to observe participants without always being explicit about his purpose, however the ratio of benefit to harm was judged as being low as the researcher conducted the work in units which were staffed and managed by qualified staff with a remit to provide a safe environment for occupants. All data collected was recorded in a truthful timely

manner and the researcher avoided making any commentary on it onsite to ensure that his biases were minimised. This extended into the analysis phase where the researcher was mindful to refer back to the original data sources ensuring that the descriptions and quotations used in the final report were true to what was recorded.

6.6.4 Management of Justice

The principle of justice conceptualises equality of access to the benefits of the research. Participation may vicariously benefit participants through the opportunity of narrating their story. Vicarious benefit to an individual during the process while welcome is outside the researcher's remit. The culmination of the research, which includes a commitment to publish outcomes allows for equality of access to any potential benefits of its application. The researcher's role is directed to discovery rather than assisting the organisation to peruse its stated aims (Long, 1997)p6, however the researcher has a moral responsibility to ensure that the discovery as a result of the research is made available to the organisation giving them the option to utilise the research outcomes. Discovery is not always welcome as discussed in the preceding chapters the truth is not always beautiful and repression operates to protect the symptom of services. When Scheper-Hughes (2001) returned after twenty years to the village where she had conducted research she found a group of people who were hurt and angry. They willingly participated but were unprepared for the appearance of their stories in a text;

“You are like the village analyst and we are all on the couch. We can't stop ourselves from talking.’ It makes no difference that I was not back looking for secrets, there was simply no way of escaping them. In the small world, words are as dangerous as hand grenades or bullets, as much for those who gave as for those who receive them’ (Scheper-Hughes, 2001)p323.

In light of Scheper-Hughes (2001) experience it is essential that participants are treated justly and that the final report presents a true but balance perspective on what is discovered.

6.6.5 Management of Respect for People's Rights and Dignity

Respect for people's rights and dignity is inclusive of privacy, confidentiality and self-determination placing responsibility on the researcher to protect participants' vulnerabilities and take into account their ability to make autonomous decisions. This

principle was managed through informed consent and self-imposed limitation during observations. One of the tasks of the analyst is enabling the analysis to progress through the management of transference. The analyst makes explicit his desire to work with the analysand who retains the option to discontinue when he desires, the researcher offered this option to participants when consenting for formal interviews. In overt observation participants know they are being observed and by whom, (Howitt, 2005) fulfilling the principle of informed consent. Some studies make deliberate attempts to study people in real life contexts bypassing the principle of informed consent, in such circumstances the privacy and psychological well-being of the people being studied should be respected;

‘Unless informed consent is obtained researchers should only observe in situations where observation by strangers is normally expected, restricting researchers to settings such as public social situations’ (British Psychological Society, 2001).

Overt observations were conducted however as identified by Foucault (Foucault, 2006, Foucault, 1975), mental health services are places of observation, often observation by strangers, staff observe patients and each other, inspectors and managers observe staff, patients observe each other and their observers.

Informal interviews the opportunistic conversations did not always allow for making consent explicit and is justified on the bases that it would have inhibited the free flow of the conversation and may have prevented access to rich data. Occasionally participants’, who engaged in opportunistic conversation, realised that the conversation may be included in the report, this was confirmed and on no occasion did a participant ask to withdraw or have their comments excluded. In deference to respect for participants the researcher responded openly and frankly to questions about his purpose while remaining aware of any possible harmful consequences and mindful of treating participants respectfully as equals, full open discussion was encouraged to minimise elements of distrust.

‘This very openness means that research often fulfils the desired general principle of ‘informed consent’, avoiding problems of deception which beset a lot of psychological work’ (Banister, 2006)p175.

Psychoanalysis puts a high value in the confidential nature of the work, affording it a privileged position. The discourse between analyst/analysand is not discussed by the analyst with others and the analysand is encouraged to treat the analysis similarly. Researchers guarantee participants confidentiality; confidentiality has limits that need to be clearly stated, particularly if the researcher perceives a risk of injury to the participant or another either as a consequence of participation or arising from another cause, which may be disclosed. All participants were protected to the level of ensuring that material used in reporting the research limited biographical details.

6.7 Reflexivity

Taylor (2006) presents a naïve approach to reflexivity describing it as;

‘How the researcher positions themselves within the context, process and procedure of the research, is of central importance in understanding the perspectives of the people being looked at: the researcher and researched are part of the same social world’ (Taylor, 2006a)p37.

Lacan according to Parker (1992) has a negative view of the way self-reflection operates in that it ties the individual to relationships, defences and repressions as the ego represents the centre of resistances indicating that the ego of the researcher cannot do both reflect on and free itself from resistance at the same time (Parker, 1992)p108. The position of observer can be distinguished from the literature’s description of participant observation but it is not simply nonparticipant observation, fieldwork, included observation and interviews imply an additional level of engagement. Interviews require researcher participation and even maintaining quite presence implicates the researcher in the process. Hollway and Jefferson (2007) construe both researcher and researched as anxious;

‘Defended subjects whose mental boundaries are porous where unconscious material is concerned. This means that both will be subject to projections and introjections of ideas and feelings coming from the other person. It also means that the impressions that we have about each other are not derived simply from the ‘real’ relationship, but that what we say and do in the interaction will be mediated by internal fantasies which derive from our histories of significant relationships’ (Hollway, 2007)p45.

Observing but not engaging in group’s activities causes elements of reactivity from participants both conscious and unconsciously. For example when conducting

observation in a unit area, where different activities and conversations may occur simultaneously, why would the researcher choose to listen more attentively and report on one over another. Pragmatically one conversation is louder easier to hear and report accurately or arguably a particular incident appeared more dramatic and draws the researcher's attention. Alternatively what was being related referred to something on which the researcher already has some knowledge and therefore they are drawn to the opportunity to expand or extend information. These choices should alert the researcher to analysis their motivation by including and recording their thoughts and responses to the data. In other words transference and countertransference are liable to colour the observation and interview process.

‘This analysis would also require a reflexive analysis of the position of the analyst, something Lacanian's insist upon in the argument that there is no other resistance to analysis than that of the analyst’ (Parker, 2005a)p173.

This argument bases is that it is not possible to produce or receive language without being positioned by it.

Psychoanalysis aims to bring about a positive change through the transference. Analysis provides an intellectual interest for the analysand who initially gains new access to energy through the transference. The analysand will only avail of this energy in so far as he is engaged through the transference. Successful engagement is required to hold the analysand initially; subsequent work strengthens the transference. This principle applies to all work activated by a therapeutic alliance requiring the psychoanalyst to take and maintain a particular position from the onset. The psychoanalytic researcher is required to adopt a similar presence from the onset of the investigation, an analytic position designed to observe and in interviews evoke responses.

Writing a reflexive report requires the author to maintain self-awareness and in a psychoanalytic study dictates the addressing of transference shifting report writing from a technical to a representational exercise. The final text represents something for author and reader possibly beyond the author's intention. Reflexivity includes how author and reader relate to the text as such reaction helps to locate it in additional systems of meaning.

‘There is a great deal of truth, and no doubt too much truth, in the claim that a text is constituted in a reading – a reading we must add, of the unconscious – such a ‘truth’ does not exclude the possibility that there be a form of writing that is not based upon such a reading: a writing that is also an act of creation and invention which modifies the structure of the subject in its relation to jouissance and to knowledge’ (Dravers, 2004)p207.

This acknowledges that the reflexive element of writing modifies the structure of the author. Dravers (2004) argues that a knotting occurs between writing and reading ‘in the claim that a text is constituted in a reading’ (Dravers, 2004)p207, of the unconscious. Writing this report modifies the unconscious of the writer perusing it modifies the unconscious of the reader.

‘Ultimately, the importance of a text may not be what is written there in two dimensions on the page, but what is felt, what is one dimensional, the dialectic of the edge and hole present in the text – in short, the text’s topological aspect’ (Watson, 2004)p124.

6.8 Conclusion

A summary is a reduction a condensation of an extensive field of knowledge and a mechanism of the unconscious, Freud and Lacan identified the role of language in constructing the world and condensing representation in the unconscious. Lacan produced topography of the unconscious, a series of matheme to enhance our understanding a shift from typography to a topology. Topology shows structure but does not represent the subject, something additional is required, a typology of the subject inclusive of his symptoms. Within Lacan’s topography the symptom is understood and used;

‘To show how it’s typical social function is the ideological one of sublimating an esteemed ‘Fathers name’ signifier through identification with some leader’. The Real of the symptom ‘speaks’ the topological language of contradictory and paradoxical meanings that compose impasses or knots in the meaning on any person’s life’ (Ragland, 2004)pxv.

The method described in this chapter was designed to discover the impasses or knots in the management of transference in the mental health services. Attention has been given to the process of gaining access to a suitable setting and the collection and subsequent management of data. Particular attention has been given to conducting

observations and interviews linking the process employed to the psychoanalytic interview. Recognition that psychoanalysis can provide a provocative narrative, a typology, to fills the gap in the subjects' understanding by translating what is unconscious into consciousness in tandem with an unconscious re-jigging of the subject understanding is emphasised. This method has been carefully constructed so that it adheres to ethical conduct in conducting research while acknowledging the subjective position of the researcher by incorporating a reflexive element in the analysis. The method places emphasis on describing the operationalization of psychoanalytic research. The method as described produced findings presented in the next chapter and enabled analysis of the data around identified psychoanalytic formulations that emerged resulting in the identification of symptoms of the mental health service.

Chapter 7 Findings

This chapter presents integrated data from all sources to demonstrate the management of transference. Participants' verbatim quotes are included as evidence to support the analysis. The data collection phase, generated field notes, comprising of accounts of MDT meetings, observation in unit offices, day rooms, activity areas, and in additional settings, including entrance halls, corridors, car parks, the library, the dining room and offices. Formal and informal interviews were conducted. Data were collected over twelve months and initially clustered into two sets;

- The Settings
- Psychoanalytic Formulations

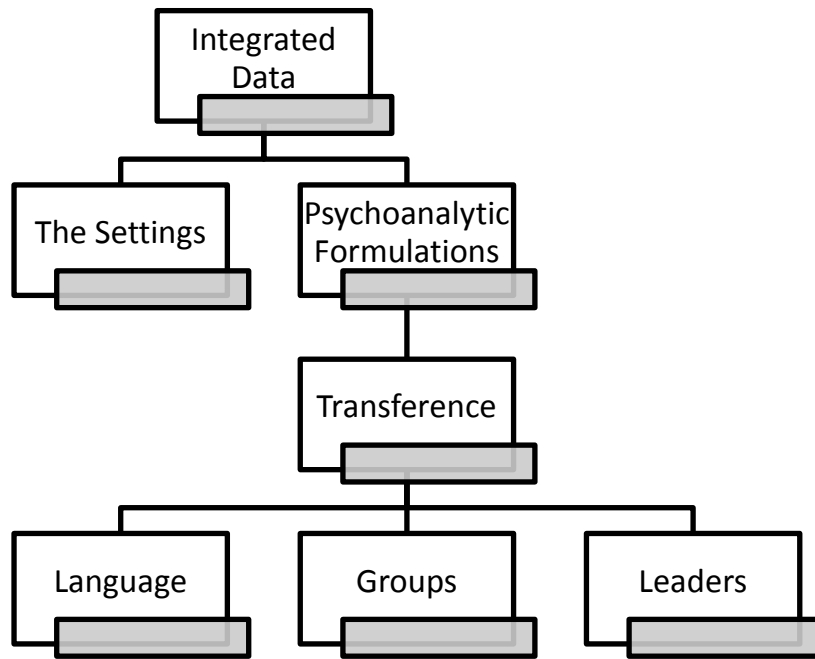
Cluster one, The Settings, contained descriptions and reflections on the physical environment and its distinctive social and cultural practices inclusive of the laws policies and procedure of central government and the HSE. Two approaches have been taken to providing information about the settings. Descriptions are provided in the introduction and methods chapters to contextualise the report. The analysis of the unconscious social and cultural practices pertinent to the settings, are provided in this and the following chapter enabling a reading informed by the structures in which participants operate.

In this chapter the speech and actions of participant's are given precedence over the physical aspects of the site, enabling a concentration on cluster two, The Psychoanalytic Formulations. Formation of the unconscious; are those phenomena in which the laws of the unconscious are observable; jokes, dreams, symptoms, lapsus and parapraxes. The mechanisms involved in the formation of the unconscious, condensation and displacement is described by Freud as the laws of the unconscious; Lacan redefined them as metaphor and metonymy. For this study the term formation is inclusive of all psychoanalytic concepts used during data analysis.

Analysis of the clustered data in relation to transference resulted in the development of primary headings which are used in this chapter to present the findings (Diagram 1

below). Additional diagrams are used at the start of each section to denote how findings under each formulation are presented.

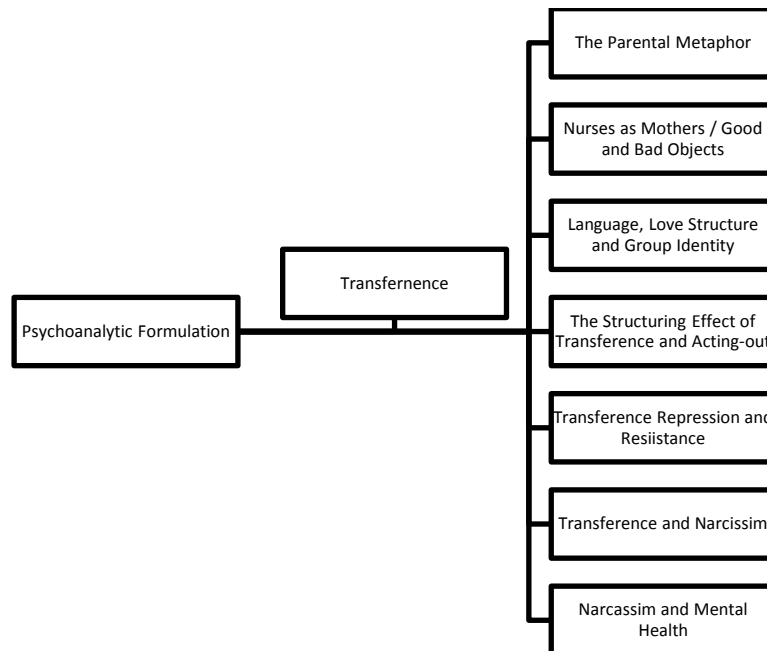
Diagram 1 Primary Findings Heading's



Transference is the primary theme explored, fitting with the psychoanalytic understanding that transference is the rock on which an analysis will progress or flounder. Language, the medium through which we understand and articulate the world, provides a second structure. Thirdly as subject-Other relationships have been explored in relation to a specific social context group formation is considered. Finally the literature reviewed and data generated identifies the leader as a fourth essential category.

7.1 Psychoanalytic Formulation: Transference

Diagram 2 Psychoanalytic Formulation Transference



The findings on transference are examined in relation to the deception of love and the enactment of the parental metaphor. Attention is given to the unconscious equating of nurses to the primary object of the (m)Other (Menzies Lyth, 1988). Two related formulations language and group identity are introduced. The role and function of transference in creating an unconscious structure that becomes part of human performance and interpersonal functioning is addressed and related to acting out (Freud, 1915b, Lacan, 1960-1961, Rowan, 2000, Main, 1957). The repetitive quality of unconscious material that is resistive to exploring symptoms and supportive of continuity in transference is identified in the action/non-action of staff. Narcissistic elements are exposed and the intellectualisation that substitutes for therapeutic alliance identified.

Menzies Lyth (Menzies Lyth, 1988) holds that in addition to the patient regressing, the nurse overwhelmed by the patient's condition is subject to massive regression, the

nurse cast in the role of (m)Other unconsciously participates taking on the role of (m)Other;

‘They still warrant an admission because they are very unwell and their families are sick of them’ (PN10).

This quote sets the scene that is repeatedly acted out in services, staff substitute for family when their quota of libidinal energy is exceeded.

Lacan concurs with the enactment of transference as an instinctual force stating that ‘the transference is usually represented as an affect’ (Lacan, 1994)p123. The affect here is represented in the *‘sick of them’* phrase which is experienced by the biological and adopted service family. Positive transference is normally identified with love whereas negative transference is never identified with hate; instead we normally employ the term ambivalence which suggests that;

‘it would be truer to say that the positive transference is when you have a soft spot for the individual concerned,, and the negative transference is when you have to keep an eye on him’ (Lacan, 1994)p124.

Participants repeatedly evidenced that they were *‘sick of’* the patients alongside differentiating between good and bad patients and consultants that you might want to work with and that you have to keep an eye on, as they appear to make choices about working only with un-troublesome patients;

‘You see how busy we are and bed blockers, there does not seem to be anywhere for them to go – ahm – you talk to the consultants, their hands are tied as well. Yet some of them, in the community, they just seem to have the same patients, you know, good patients if you know what I mean, if there is such a thing as good patients, but they are the ones that they want and they don’t want the troublesome ones or ones that they have to work at’ (PN10).

‘What is fundamental is that transference love – as Freud rightly pointed out – is true love, and love, in turn, is necessarily a deception’(Harari, 2001)p96.

Desire is a deception because to desire is desiring to be desired. The libidinal drive is active but its aim is passive, its aim is not to love but be loved and to be loved by the leader would be more rewarding;

‘Someone up above just to think of the staff on the floor and try and ease, just a little, it sounds stupid, but just a little relaxation room or something to go to’ (PN10).

The lack of love in the system, the gesture requested as an escape from *‘the troublesome ones’* is indicative of the desire to be loved by the Other and for a share of the jouissance generated by the foot soldiers. The lament is without acknowledgement that the relaxation room would only provide temporary respite as the preferred option of dismissal of all patients is unachievable.

7.1.1 The parental metaphor

The non-recognition by staff of complicit participation in re-enacting early formative relationship leads to the creation and long-term maintenance of a system inhibiting progress. Staff acknowledged the parental role they take and the difficulties they experience in stepping away from this;

‘There is more structured therapy groups and programmes. It’s very slow and time consuming we are changing staffs mind sets. Patients are to be treated it’s not just give them tablets and things like that’ (PN2).

Within conscious acknowledgement of the difficulty in implementing change there is evidence of patients as object rather than subject, *‘patients are to be treated’* (PN2). They remain part-owned by staff undifferentiated and disallowed from engaging in decision making processes.

7.1.2 Nurses as mothers / good and bad objects

Participants articulated ambivalence and anxiety arising from internal sources and reason that maintaining silence is for fear of persecution; fear about staff responses to disclosed feelings and beliefs. Klein (Klein, 1952) describes the infant’s fears that the mother will destroy and annihilate them. Talking to nurses was credited as comforting, indicative of the infant’s ability to split off good and bad parts of themselves and attribute these to the external source of comfort, the mother. Staff recognised this aspect of work;

‘Being able to listen is the most important thing. That’s what people want more than anything, is to be heard. If you are willing to listen whether you agree or disagree, that’s where your relationship starts’ (PN2).

Acknowledging the non-judgmental stance is a first step in movement from a social to a therapeutic relationship a prerequisite for analytic discourse, however there was also criticism of hospital based staff;

‘I have seen great changes – changes of the interaction of the nurses with the patients. They are more on the computer now – they do marvellous work and I guess it is not up to the hospital to engage in conversation with the patients, it’s up to them when they are diagnosed or whatever it is up to the clinics or day hospitals or the places afterwards. But the nurses do give you time to talk to, but not a lot, because there is oh so few of them and so many patients they can’t just take us they couldn’t they would be under resourced to do that – you could not ask them they are run off their feet. Very, very busy – they still have time to say hello and have an exchange with you- a few remarks here and a few words of comfort there – you know – no they are wonderful’ (PN1).

Transference appears ambivalent and contradictory, nurses ***‘are wonderful’*** but there are limitations to their wonderfulness that patients must accept, like busy mothers they have limited time they have to be content with, a demand for more time or engagement is unacceptable and may result in the harshest of punishments the withdrawal of love. Staff like real mothers responded as mothers to patients;

‘We have one particular lady who has been in and out for well let’s say the last seven or eight years and its only recently her mother said, ‘I am not having her anymore’ (PN10).

The rejection of the patient by her real mother is repeated in the hospital;

‘She ended up in here; I think it was for about four months. So and it was only when her mother realised who all the characters who were coming in and out of the house, that what she was doing you know. She threw her out and so it ended up that she was here then with us for ages because she had no-where to go. So she was discharged then two weeks ago and she is in the homeless service now, so I don’t know how she is getting on you know’ (PN10).

The patient rejected by her mother, rendered homeless by her family, after a period of time in hospital experiences repetition, rendered homeless suffering the loss of the

(m)Other an additional time. This uneasy experience for the patient and her mother, severing their cohabitation and having the severance repeated is supported by rejection;

‘It took a lot for the social worker to actually get her out of here because she was refusing to go you know. She is gone and we haven’t heard anything from her, so hopefully she won’t’ (PN10).

7.1.3 Language, love, structure and group identity

Transference is ubiquitous, with unconscious expectations of repetition. Patients actively seek a sense of belonging. When this is not available in the traditional institution they are driven to seek it elsewhere. An invitation on a notice, *‘Do not be alone’* (PN1), motivated the participant to join a club. The opportunity to be part of a group offered relief from isolation and opportunity to engage with others. It provided a chance to be loved by others, an experience unfelt at home or in services;

‘I am alone I was talking to no one I was cut off I felt rejected by everyone – I am alone’ (PN1).

The desire to belong coexists with anticipated loneliness, the club advertising a relief from loneliness is required to offer a radically different engagement to the unconsciously anticipated repetition outcome. The opportunity to engage with others allows identification to take place.

7.1.4 The structuring effect of transference and acting-out

Acting-out equals’ transference without analysis, staff respond to incidents of acting out and are as prone to acting out as patients (Harari, 2001, Main, 1957). There is a reciprocal nature in the unconscious fears and primitive fantasies evident in mental health units. Critical incidents, evoke omnipotence and aggression in staff, managed by the imposition of treatment often the administration of medication when staff can no longer tolerate the anxiety, impatience, guilt, hatred, and despair evoked by patients (Main, 1957, Shur, 1994). Acting-out is the demand for love an attempt to avoid anxiety.

Observed incidents of acting-out contained elements described by Freud (1917), Lacan (1960-61), Main (1957), Shur (1994) and Hari (2001) that relate it to transference.

‘I noted a new sign on the office door; ‘Strictly no mobile phones charged’. The Unit appeared busy and there was a lot of staff activity, nurses were moving quickly and purposefully about the unit, the noise level was greater than usual, there was a distinctly tense atmosphere. The new notice on the door indicated tension between staff and patients and this was confirmed a moment later when a patient came to the door to complain about the state of the toilets and was curtly told that cleaning was in hand’ (FN9).

The notice, the urgency and curt responses are unnamed and unacknowledged negative transference and anxiety, activities designed to keep the patients at bay, staff’s unconscious defences. The cause was not apparent but an incident occurred shortly afterwards confirmed the belief that staff were experiencing elements of work as overwhelming and guarding against this.

‘I was not in the office long when a student nurse came in and whispered something to a senior nurse. I could not catch all that was being said but managed to pick up that a patient was doing something in the unit toilet. ‘She is looking for trouble again’ (FN9).

This critical incident which firmly places a negative locus of control with the patient, had to be reported, but as a whisper.

‘Both left the office immediately and the senior nurse returned a few moments later for disposable gloves. Some time passed and I continued to observe what was happening while chatting to a Staff Nurse who had recently completed a post graduate programme and was now working in the unit and enjoying the experience. In the background I became aware of a loud distressed inarticulate babbling and shouting coming from the bathroom area. After this settled down, a number of nurses returned and discussed the incident. The patient had told the student she had inserted a pouch of tobacco into her vagina the night before and was now in pain and without cigarettes. The senior nurse put the patient in the bath, notified the duty doctor and decided that the patient should be sent to the local general hospital accident and emergency unit’ (FN9).

This incident evoked omnipotence, aggression and acting out in staff. The inserted tobacco pouch was intolerable for the patient and staff, for some even too much to

articulate so action in the guise of treatment was imposed. Staff no longer able to tolerate the anxiety, impatience, guilt, hatred, and despair evoked by the patient and the failed defences of notices and curtness culminated in a counter-transferential acting-out. The patient unable to speak can only act-out and regress to inarticulate babbling and shouting. The inarticulate staff's tolerance is over saturated and they opt to remove the patient from the scene, dismissal.

'A staff nurse came into the office and announced that the patient had now removed the tobacco pouch and been taken back to bed. The doctor and the possible transfer to the accident and emergency unit were no longer required. 'She took it out herself. It's all in a day's work. Now she is looking for a pain-killer. She only did it this morning. I saw the pouch on her locker this morning' (FN9).

This incident reflects Main's (Main, 1957) observations on nurses reactions to increased levels of anxiety. The decision to transfer was made quickly without discussion and as quickly reversed. The patient's story, inserting the tobacco pouch the previous evening, was refuted and her request for a 'pain killer' ignored. In this critical incident, transference, master discourse and the power of the leader are observable. Staff certainty that the patient lied about the timing of the insertion, their unconscious response to the tense atmosphere and the anxiety the incident created, went unanalysed. Power is used to delay responding to the request for analgesia, it is unquestioned by everyone present. Lacan identified that if transference is not analysed, the analyst fallen from his or her place, sends the analysand directly towards acting out; and the message that could not be heard returns abruptly in a manner that can be seen,

'Acting out = transference without analysis
Transference = acting out without analysis' (Harari, 2001)p84.

Combining Harari's (2001) statement, the ubiquitous nature of transference and Freud's contention that transference is in place prior to analysis, demonstrates that staff contribution to incidents of acting-out. Acting-out, presented by Lacan as having a greater power of demand than the symptom; the subject is so overwhelmed by their anxiety that they take action.

‘It is very upsetting (being turned away) you know it’s very upsetting. You know I felt like I didn’t want to be listened to or wanted and I felt rejected and – ah – I got more suicidal thoughts. Sometimes actually – ah- I harmed myself by taking an overdose because I was turned away, ya. My life was not worth living because I was not being helped and I found it very upsetting, upsetting my family an awful lot’ (PN9).

The lack of demand towards the patient contributes to acting-out more than the symptoms that drove them into care, indicating the potentially destructive or negative nature of admission. Freud emphasises the emergence of negative transference in the institution particularly when the treatment regime is non-analytic, naming it as nothing less than mental bondage (Freud, 1912)p101. Manifestations of transference in the institution are attributable to the neurotic condition; patients overwhelmed by anxiety take action. They are not asking for something, not seeking attention, they are demanding something to be demanded of them.

‘People don’t want to talk about it and won’t. People are vulnerable they feel they have nobody to talk to, you know. You feel the only way out is by taking their own lives’ (PN9).

7.1.5 Resistance

Resistance needs to be lifted to explore transference; repression is linked to resistance, the findings uncovered resistance in service occupants. The symptom par excellence of resistance is retaining the idea that standard mental health interventions, a one size fits all approach, can be applied to patients and those who do not respond favourably are resisting opportunities for recovery;

‘Some patients will just criticise. Some of them might not be compliant to anything but you take the steps to try and encourage them’ (PN4).

Symptoms evoke staff anxiety and a standard way of dealing with the otherwise overwhelming sense of powerlessness is evoked by recognising that the interventions are useless and managed by dismissal of the patient instead of the intervention, throwing out the baby but retaining the bathwater.

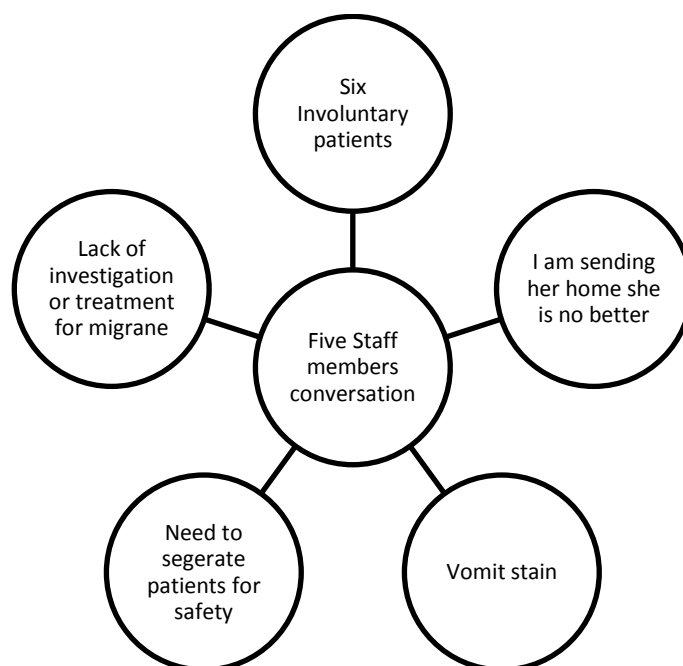
Staff were constantly concerned with bed occupancy levels including the number of involuntary admissions; one discussion on the highest number of involuntary

admission (total 6) experienced since the change in mental health legislation had the explicit purpose of changing patients legal status or discharging them from care;

‘I am sending her home, she is no better’ (FN7).

This decision to discharge the patient with no apparent improvement went unquestioned by the five staff present. Literature indicated that difficult and recalcitrant patients are transferred, discharged or scapegoated (Miller, 1972, DeBoard, 2005, Menzies Lyth, 1988, Freud, 1915b). The conversation shifted seamlessly to removing a vomit stain from a carpet and another patient being cared for in the high observation area to protect her from a patient that she had a disagreement with.

Diagram 3 Unconscious aspects of staff discourse



The recalcitrant patient to be discharged is unconsciously connected to a vomit stain that needs to be erased, she does not deserve care or segregation for safety, her presence is a reminder of failure in the system. Following the decision to discharge the discussion shifts to writing her a prescription. The doctor asks why she had a regular prescription for migraine medication and decides to exclude it. There appeared to have been no investigation of a possible link to having a migraine and

requiring admission to services. Nor is there any discussion relating to the intervention of admission to hospital having failed. The failed intervention leads to a decision to dismiss the patient. The quality of the intervention is unquestioned and retained for another.

A similar incident occurred during another patient review, when a patient requested discharge and referral to a particular day hospital. The patient's request does not match the staff plan;

'I don't know whether the team meeting with the patients sitting in is necessary a good thing, sometimes it's more stressful for the patient's than the illness itself' (FN8).

The patient requesting discharge is putting himself in the place of subject who knows and is subject to a transference labelling him as uncooperative. Staff refer the decision to the consultant the big Other, who if he supports staffs' recommendation will be lavished with unconscious love and if he rejects it, will be subject to disapproval alongside a deepening hatred for the patient. Perceiving patients, who evoke anxiety, as troublesome is repetition of a pattern in this social world.

Transference of feelings onto the patient not justified by the situation is due to the readiness for feelings derived from somewhere else to emerge; the patient merely provides opportunity for their expression. Transference appeared in the findings as a desire to keep the patient in hospital where love, can be lavished on him;

'I love that now, because that is obviously what you are trained for, to help someone and when you do feel like you are doing something for someone, when you speak to someone and you see that you have reassured them and settled them, that is the satisfying thing' (PN4).

Where staff's need for love was not satisfied in reality they approached every new encounter with another, with unconscious libidinal anticipatory ideas. Staff with unsatisfied libido directed it at those expressing an interest in and appearing to show them love. This is expressed by staff and patients as an expression of satisfaction about the work, the need for occasional respite from patients, a desire to be rid of the patient, a declaration of hate or that a patient should remain in the system;

'You see patients that shouldn't be here but they have nowhere else to go for help, it would be nice to see patients moving on' (PN4).

'Nothing we have nothing, we have the dining hall that everyone else goes to, even the patients go to it now, so you are not getting away' (PN10).

'They are very nice they are always here with me. Some people do not think it is a good idea, my colleagues, if you come too close to them and they are your friend, they feel that they can do anything' (PN3).

'I know them all (the staff) they know me. It's very good that I know the staff, ya, the staff know me and they understand that I suffer from depression you know they understand they know that I may need to come into hospital, they understand that' (PN9).

'It sounds terrible but we are sick of her' (PN10).

'I don't dislike people as a rule, so I do not dislike them. There are people who abuse the system, which annoys me' (PN10).

Transference can have a welcoming or positive quality or appear hostile and negative, a reversal into the opposite occurs. The declaration that the patient is *'showing his true colours'* is a defence against overwhelming transference, love and care have been lavished on him and he has thwarted it, staff's need to be loved is unmet.

Getting difficult patients out of the system was also a theme in community services. The excerpt below from a MDT meeting is about a married man, with children, who is seeking employment but appears to be quite disabled and unable to retain a job or manage an interview without becoming distressed. The discussion took place after he had been to an interview at the labour exchange seeking disability benefit.

*'He starts shaking when he sees people; he soiled himself at a job interview'.
'It's disassociation'.*

'He wants to work, he does not take disability – he goes on the dole'.

'In my opinion he is unemployable at the moment - he would not make the choice (dole/disability) - would you employ him?'

'We would be of the view that he is unemployable'.

'There are family issues it impacts on the wife and child'.

'The ship is sinking quickly – he sees the crisis all around him'.

'He needs containment, some kind of movement to changing things internally'.

'He has gained insight since I first met him'.

‘I think that if he left the country that would be very good – he has left two other children in two other countries – he was abandoned himself - that’s what he might do some day’.

‘A penny may drop - we have to just carry on’.

‘He is explosive he is high risk – we should keep him on the books for the moment’.

‘We should provide everything – leave everything open to him’” (FN2).

This discussion expresses the frustration experienced by staff in caring for a man who, besides having his own ideas about wanting employment and accommodation, had a history of making geographical changes when his anxiety becomes overwhelming. This was one of the most animated and open discussions observed at a MDT meeting. However staff appeared unable to help and at a meeting by the same team two weeks later had much less to say about this patient and nodded in agreement to the hope expressed that he would emigrate.

‘X has set up a meeting to go and see the bedsit with him. He seems anxious and keeps referring to the coldness – we hope to move him along quickly.

Right (sigh) it may rear its head in the next while what’s the betting – let’s see if he gets moving OK!’ (FN4).

This case management illustrates repetition of abandonment by staff, and anticipated ‘passage a l’acte’¹⁴ by the patient, the team is complicit in a desire that the symptom would be repeated. There is no review of their desire that the patient emigrates and only vague recognition of repetitive action. ‘Untamed instincts can assert themselves before there is time to put the reins of transference on them, or that the bonds which attach the patient to the treatment are broken by him in a repetitive action’, (Freud, 1912)p154. The work of the analyst to keep the analysand in analysis as ‘one cannot overcome an enemy who is absent or not within range’ (Freud, 1912)p152, is revered in mental health; staff do not put the reins of transference on the patient and actively encourage the repetitive action of abandonment. This abandonment warrants exploration from the perspective of the patient’s history of being abandoned and abandoning and staff’s complicity. There is repetition of the past in the present and negative transference, the quality of the intervention is unquestioned instead the patient is questioned and dismissed.

¹⁴ ‘Passage a l’acte’ denotes an exiting from the scene which differentiates it from acting out where the person remains in the scene the difference here is that acting out is a symbolic message to the big Other and ‘passage a l’acte’ is an exit from the symbolic order to the real, a flight from the Other.

Lacan cautions against just seeing transference as a repetition, reminding us that if something cannot be remembered it is repeated in behaviour. ‘This behaviour in order to reveal what it repeats, is handed over to the analyst’s reconstructions’, (Lacan, 1994)p129. The patient has handed over something to the team to reconstruct. Transference is the transference of power from the patient/subject to staff/Other.

‘Each nurse is allocated so many patients so that they would speak to them during the course of the day and they would write up notes. Observe them like how are they feeling, their mood, if they are eating, if they are getting involved in things and that. They would write up the notes and they would be given to the doctor. The doctor would then review you, so that nurse is responsible for you all the time, you know, where if you feel you need to speak to them, you speak to them like. The nurses would talk to you. They are very good in the hospital, very good’ (PN9).

The patient, seeking truth, assumes its location in the staff. Transference appears here with a positive quality, ***‘the nurse is responsible for you’*** is the point at which the locus of power to provide the answer containing the truth of the subject shifts from the patient to the nurse. There is a struggle between the staff and the patient, ‘between intellect and instinctual life, between understanding and seeking to act’ (Freud, 1912)p108. This struggle is played out in the transference and ‘it is on this field that the victory must be won’ (Freud, 1912)p108. The data below evidences this shift in the locus of control and an attempt from at least one member of the team to reconstruct what is happening;

‘He has gained insight since I first met him’. ‘We should provide everything – leave everything open to him’ (FN2).

In a team conflict, one member argues for exploration of the patient’s unconscious and on-going engagement in psychotherapeutic work; ***‘He needs containment, some kind of movement to changing things internally’*** (FN2). Another carries the hope that he will leave, ***‘we hope to move him along quickly’*** (FN2) and a third maintains the position that he is already lost, ***‘the ship is sinking quickly – he sees the crisis all around him’*** (FN2).

The patient has needs and longings which (Freud, 1917b), should be kept active in order to impel him to do the necessary work to make changes, but his needs and longings are resisted by the team. This patient's actions and stories have brought staff resistance to the fore, resistance to the recalcitrant patient and each other's ideas. Unable to trust each other enough to speak about failing, they hope the patient will leave, allowing them to ignore what is happening at a team level. 'Transference is essentially resistance. The transference is the means by which the communication of the unconscious is interrupted, by which the unconscious closes up again. Far from being the handing over of powers to the unconscious, the transference is, on the contrary, it's closing up' (Lacan, 1994)p130, it is effectively closed up by staff resistance with simultaneous displays of identification with the leader and contagion of affect.

7.1.6 Transference and narcissism

Contained in the myth of Narcissus¹⁵ is the salutary warning that love, to be productive, needs to be aimed at another as opposed to an image of the self. Being narcissistic involves placing an inflated value on one's own position to the extent that the other is excluded becoming a fading echo. Narcissism was a feature of staff beliefs about the value and extent of their input with patients;

'The biggest thing we do is to be there, talk to them encourage them, reassure them... Just to be an ear for them because some of them all they need is someone to listen and obviously the medication aspect and sometimes the physical. Some of them have physical problems. It's just to look after them as a holistic, a whole person, whatever they need are we here for them' (PN4).

Narcissism reveals significant valuing of physical presence and listening balanced by placing equal emphasis on medication and physical aspects of care. There is both the expression and disavowal of belief that psychic readiness to engage with the patient is sufficient. Most importantly is the metonymy of the final phrase '*are we here for them*', a dialectical reversal converting the passage from statement to question.

¹⁵ Narcissus was so in love with his own reflection, so taken by the beauty he beheld that he did not recognise it as a reflection; instead took it to be another. His love for the reflection was so powerful he ignored calls from the nymph Echo who consequently faded away and disappeared

7.1.7 Narcissism and mental health

Staffs' narcissistic neurosis is fuelled by the indispensable quality of their work. They readily engage in intellectualisation which allows relief from the patient's and institution's symptoms, but are unable to work successfully with transference; instead they manage it in three ways;

- Dismissal (hate)
- Recourse to intellect (dismissal)
- Parental care fostering dependence at the level of (m)Other.

Contrasting altruistic approaches appear in the speech and actions of staff;

'I have dedicated my working life to working with the mental health service, it becomes a personalised experience at some level' (PN5).

Narcissistic rivalry exists between service providers indicating despite evidence to the contrary a strong belief that their approach to care could not be rivalled;

'Staff were critical of the care in general hospitals, saying that patient's activities of daily living were not attended to and that more organisation was needed by general nursing staff in managing wards and emergency departments' (FN1).

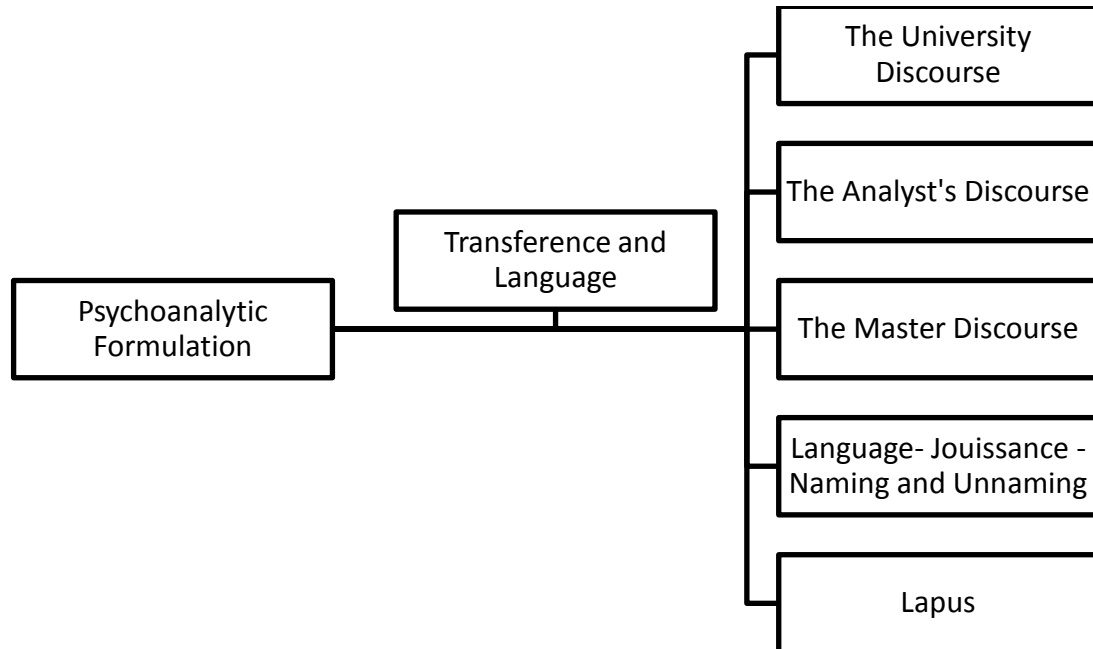
There are also indications of rivalry between internal staff groups fuelled by narcissism and the difficulties encountered in the work which causes staff via transference to dismiss patients and colleagues;

'I don't think the majority of patients need to be in hospital if there was proper outpatient care' (PN2)

'they are back in here and – ahm – we have to deal with them whereas the nurses in the community also who have psychiatric qualification the same as us because we are not super people so the same consultants are going out to deal with their patients that come in here so I don't see why they can't manage them in the community you know' (PN10).

7.2 Psychoanalytic Formulation: Transference and Language

Diagram 4 Psychoanalytic Formulation Transference and Language



Lacan's discourse theory and structural theory are used to explore participants' speech and jouissance under the second formulation transference and language. Symbolic representation, the articulation of subjectivity, affects and the relationship to the Other are presented. Parapraxes, lapsus and the paradoxical existence/lack of professional jargon by groups inhabiting services are considered. Fink (1995) argues that analytic discourse is not the ultimate discourse but worthy of our attention because 'it allows us to understand the functioning of different discourses in a unique way' (Fink, 1995a)p129. Individuals unconsciously operate in different discourses depending on the social world they occupy. Lacan's discourse theory provides a linguistic construction of transference via four social bonds determining the social functioning of the institution.

7.2.1 The University Discourse

In the University discourse knowledge is understood as a defence against the truth, product, the generation of knowledge, is preferred over the unconscious. The knowing subject is the agent and the unconscious remains excluded. The university

discourse does not come to terms with the Real of the world, striving instead to catalogue every aspect of it;

‘This is supposed to be a MDT meeting people should be here on time.’
(Repeated twice – yet no one was late on this occasion). *‘Part of the function of the meeting is to air all of the issues the reason they do not have to go through psychology is reviewed.’*

‘I agree with that.’

‘I have clinical responsibility I am here all the time unless I am in court for a patient. This is about those who do not understand all the ins and outs of psychiatry, also the medical model, do not understand all the issues. There will also be cases where psychology is not required. If the psychologist is here we can use his skills – we need to protect his time. Are people happy with that?’

‘More or less’ (FN4).

The leader claiming their function is to use exclusive knowledge to oversee exchanges and decisions at the meeting as some members lack the required knowledge, *‘all the ins and outs of psychiatry, also the medical model’*, and therefore are incapable of making decisions about who should review and treat a patient, identifies themselves as the knowing subject. Prior to this recourse to medical discourse as central to decision making, there is dismissal of the psychological assessment of patients, *‘the reason they do not have to go through psychology is reviewed’*, giving medical knowledge preference over psychology. This exchange is an exemplifier of a social bond constructed on a University/Master discourse. Perceived changes in the management of meetings were seen by some as a shift away from a university discourse;

‘There was a time where there was a hierarchical system, I can’t say it. There was a consultant and the nurses were on the bottom of the team and I think that has changed and the doctors respect the nurses’ opinion more, respect their knowledge more. I don’t know whether the team meeting with the patients sitting in is necessary a good thing, sometimes it’s more stressful for the patients than the illness itself’ (PN2).

Exclusion of the patient from discussing diagnosis, treatment and prognosis is offered as protective of their vulnerability. Exclusion enables the team to freely impose medical language on the absent subject, reserving the bottom rung of the hierarchy for the patient.

7.2.2 The Analyst's Discourse

In psychoanalytic practice the analysis must be truthful to the analysand's searching for truth believing it to be located in the Other of the analyst. 'Groups are not interested in truth, they demand illusions and cannot operate without them, giving the unreal precedence over the real' (Freud, 1921a)p80. Groups shelter themselves from the truth in myths and legends symptoms that protect the group. Disregard for the truth extends to sacrificing it to maintain group survival. Energy is diverted away from stated primary tasks into maintaining illusion. Freud links language to truth implying that in language the truth can be discovered. Lacan argues that the articulation of the truth is the articulation of desire (Lacan, 1993a)p144, valuing the truth for understanding madness, and holding that modern science renders madness meaningless by ignoring the concept of truth (Lacan, 1993a)p153. Truth and deception are linked, the analysand who lies is telling the truth in an inverted form. Part of the work of analysis is to expose this deception to the analysand and point out the truth it contains. Truth is not always beautiful and certainly not always welcome;

'As nurses on the ward 24/7 we tend to know the personal side of the patient more and they would tell us what's going on and you know inside in the meeting, (MDT meeting), they are not being truthful to themselves. But that is why the nurse is there to fill in those gaps. You will get patients who will say; 'I never slept all week.' Because there is no nurse there to say; 'Well actually you did or you never take your tablets every day.' If you have the whole team there are people to notice where the gaps are' (PN2).

This nursing truth is not necessarily the patient's truth. Exclusion enables the avoidance of truth about the system's structure maintaining the patient account as untrustworthy. The nurse's desire to be the desire of the Other is unchallenged, her rivalry for attention given free rein. There is a gap about truth and absence of analytic discourse. The service on the couch disclosed the truth in a convoluted deception as when the patient is allowed to speak they identify the paucity of the discourses encountered and the almost total lack of analytic discourse (Policy., 2005).

7.2.3 The Master's Discourse

Data identified the doctor in the role of Master, consequently his words are given special significance for example; PN10 identifies the doctors *power to discharge* recalcitrant patients PN4 identifies the doctors *exclusive knowledge about*

medication, PN1 describes them as *Gods*, PN5 talks in terms of *medicalised professions in numerical ascendancy* and in MDT meetings the order of events is strictly controlled by the Consultant.

‘The master must be obeyed – not because we would all be better off that way or for some other rationale - but because he or she says so. No justification is given for his or her power it just is’ (Fink, 1995a)p131.

The master is in a position to address the slave who works for and produces something; knowledge for the master. Hegel identified that the master can only exist if there is a slave to carry out his bidding (Audi, 1999), consequently the role of master is often conferred on an individual, a position not necessarily of their choosing. Patients are described as unresponsive to nurses, they will not obey them. To manage this, maintain order in the system and restore the established pecking order, the doctor is exalted to the role of Master and called on to deal with recalcitrant patients;

‘They’d all be in and they’d all not go to therapy. There would kind of be the revolt then when they would come in against the nurse, and we’d be, our hands would be tied, we would have to get the doctors in to discharge them’ (PN10).

This recourse solves an immediate problem but contributes to the retention of the master/slave structure and established transference relationships, alternative analytic discourse is not considered. The Master has no interest in this knowledge his concern is that the system and the subjects in it works. Thus the produce of the subjects, complaints about the patients, has a surplus quality, enjoyable by the Master as surplus jouissance. Understanding the master as represented by any staff and the patient as subject, the patient is required to work at his illness; produce an increase/decrease in symptoms for the Master. Staff are unconcerned with this increase/decrease in symptomatology, the patients’ product/loss, recovery/symptom, and this gives staff information on which to base services, such as discharge the current group and get different ones in. There is a jouissance for staff in patient’s symptoms supporting the system with excess to fuel system development allowing the Master to conceal that he is no different to the subject, he also operates in language, a subject split between conscious and unconscious.

7.2.4 Language – jouissance – naming and unnamings

Language is an intrinsic part of inter and intrapersonal experience, language resonating in and around us sustaining the psyche. We give the objects, subjects and affects that structure experience, names to make sense of existence, convey meaning and evokes responses. Participants, with the exception of one group, nurses, had a specific set of signifiers in the shared language of the group to describe their work. Other professional groups and patients appeared to have a jargon to articulate their position. Nurses lacked consistent professional language and used general terms to describe patient conditions often in a vague and non-specific manner. This lack of language was noted by a number of participants;

‘I find that if you suggest something on medication you always get their medical terms thrown to you’ (PN4).

Others noted that some members were extremely articulate and had a body of language to describe engagement with patients thus disadvantaging nurses who were unable to describe their position. This included taking a sympathetic position in relation to nurses, acknowledging their time with patients, their role in service management and organisation, and the hierarchy structure that dominated their participation alongside this failure to articulate. The regression that occurs when a patient enters the system evokes primary affects subjecting the nurse to powerful introjections and projections.

‘And I am on a committee myself. It’s called a therapy development group but it’s actually patients therapeutic interventions, I am blocked for words now, but it’s more of a group to find out what patients need more and it was called originally the therapy development group because we were trying to improve the therapy’ (PN2).

‘I was frightened to talk, I could not find a beginning, it was so tangled I was talking in reams. I relied mostly on the nurses, being feminine they could calm you. I would not trust anyone at all to understand to know me- I was afraid of myself and the power in my head’ (PN1).

Being ‘*blocked for words*’, (PN2), when trying to articulate ‘*therapeutic interventions*’ alongside the patient’s desire and a fear of talking alongside reliance on nurses calming influence, gives the nurse a specific quality outside of language

experienced but not articulated, as the (m)Other imposes desire on the pre-linguistic infant. It is an encounter with the real, associated with overwhelming anxiety, managed here by the mothering quality of nursing, ‘what we experience as unbearable suffering is experienced by the unconscious drives as, on the contrary, a satisfaction’ (Leader, 1995)p141. Freud’s version of transference as both tool and enemy of analysis indicates that this development between patient and nurse is a false connection that needs to be worked through. Lacan articulated how our desire is to be desired and transference is initially addressed towards knowledge therefore staff become desiring subjects supposed to know. The patient is separated from knowledge they expect to have about themselves, the knowledge is located in speech, the symbolic order. The patient experiences both alienation and separation from knowledge of themselves and expects to find it in staff;

‘They would assess you and they see how serious your condition is and they would take your clothes off you and you would be assessed by the nurses’ on-going’ (PN9).

With insufficient language, patients regress into an imaginary relationship with the image of the nurse where they experience jouissance, basking in the love or punishment received in the manner of the infant, prior to entrance into the symbolic order, basked in fulfilment at the mother’s breast or alternatively striving to destroy it.

Jouissance occurs outside language and has an unbearable quality of extreme suffering requiring regulation in the social order, imposed by the nurse;

‘You do have a lot more nurse involvement with structured groups, well we always did things but now they are more structured more one to one more things available’ (PN2).

The acknowledged role of nursing in service management and organisation separates them from other clinical staff.

Participants identified with names while accepting that in mental health services name changes are a frequent pattern of attempts to categorise the un-categorisable; The ‘*therapy development group*’ is ‘*actually patients therapeutic interventions*’ (PN2). PN1 without confusion described a ‘club’ attended which had three name changes;

‘The Basin Club, SI and Shine’ (PN1). This pattern was also observable in staff discourse;

‘I was told that people attending the day hospital were referred to as patients and people attending just for psychotherapy were called clients’ (FN1).

Names are critical to understanding reflecting content and meaning.

Metaphors played a significant part in participant’s description of others and services.

‘I am eternally grateful to the doctors and nurses, I think their profession, fire brigade men, the whole lot of them, I think they are all Gods in their own right you know. They do not have to be spirits on their knees that you are praying to. These people are doing their purpose and God’s will and they are wonderful people and lovely really truly lovely’ (PN1).

This language shows the strength of transference, like firemen, staff provide emergency services that save you from danger, the danger of burning in the eternal fires of hell, staff are Gods, the ultimate Big Other. Within this powerfully apparently positive and exalted description there is a parapraxes; ***‘they do not have to be spirits on their knees that you are praying to’***. This reversal places the staff rather than patients on their knees negating any need to pray to them as ***‘they are doing their purpose’***, addressing their own needs. In PN10 speech above the ***‘hopefully she won’t’***, is an example of parapraxes, an expressed hope that the mother is now free of the troublesome daughter and if she does not hear from her again, neither will staff. Notably the more challenging the incident the more metaphor was utilised in attempts at sense making and justification of interventions, for example in the MDT meetings on the patient staffed hoped would emigrate;

‘The ship is sinking quickly A penny may drop He is explosive he is high risk’ (FN2).

7.2.5 Lapsus

Psychoanalysis includes distinguishing between empty and full speech. The analyst works with the speech of the analysand.

‘He takes the description of an everyday event for a fable addressed to whoever has ears to hear, a long tirade for a direct interjection, or on the other hand a simple lapsus for a highly complex statement or even the sight of a momentary silence for the whole lyrical development it replaces’ (Lacan, 1993a)p44.

‘This sound’s terrible – not the neurotic side – there are people here who are very genuine and need a lot of help. The service is over used. I think there are people who should not come into hospital; it’s not beneficial to their health. I know some people like being in. Sometimes the hospital thing causes more harm than good’ (PN2).

Exploring this statement as deception discloses the unconscious. ***‘The service is over used’*** reveals the belief that some patients should not be admitted and admission is harmful. Harmful for staff listening to and caring for those who are not genuine and need little help, patients are split into two groups neurotic and psychotic, the neurotic clearly not deserving care. This is confirmed by the next statement;

‘I don’t dislike people as a rule. So I do not dislike them. There are people who abuse the system, which annoys me, ahm – ahm – ah’ (PN2).

The participant’s rules include disliking/liking but denies it for its incompatible to admit disliking patients. This and the lapse into having no language, the ***‘ahm – ahm – ahm’***, is a confirmation of this position in relation to a set of patients who should never be admitted to hospital. An earlier example provides a similar lapsus suggests disbelief that consultant’s hands are tied and a complaint about the level of support for staff alongside the admission that the good patient does not exist.

‘You see how busy we are and bed blockers, there does not seem to be anywhere for them to go – ahm – you talk to the consultants, their hands are tied as well. Yet some of them, in the community, they just seem to have the same patients, you know, good patients if you know what I mean, if there is such a thing as good patients, but they are the ones that they want and they don’t want the troublesome ones or ones that they have to work at’ (PN10).

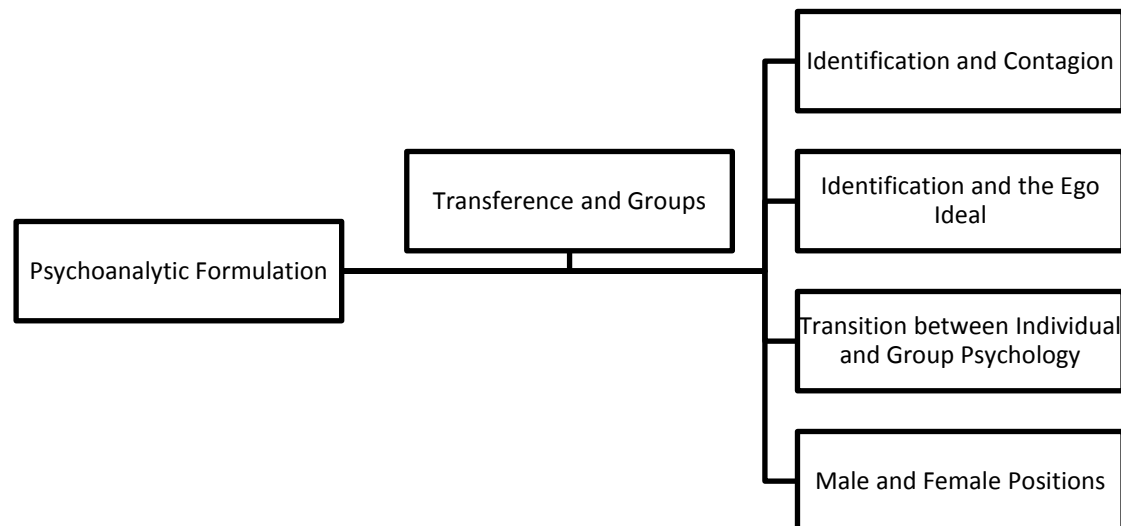
Lapsus appears in many forms such as the next example of identifying nurses as ***‘feminine’*** instead of male or female, this example speaks to the unconscious equating of the nurse to the (m)Other separate to any biological identity;

‘... nurses I was a bit scared of too – being feminine they could calm you’
(PN1).

Besides using metaphors to present unconscious knowledge, grammar is bent to describe positions *‘I am alone and I was’*, PN1’s containment of the past in the present evidences the lack of a chronometer in the unconscious and the failure to establish a transference relationship at home, in services and voluntary organisations. When language contains unconscious knowledge it fails particularly when the subject is faced with an encounter in the real as in the earlier example of the insertion of the tobacco pouch; the student could not speak the horror of the incident aloud and the loud distressed inarticulate babbling and shouting did not contain any recognisable words. Language allows the speaking of truth while consciously believing a successful distortion or deception is achieved. PN2 laments the loss of the hierarchical system of nurses and doctors, declares *‘I can’t say it’*, but goes on to criticise the present system as lacking respect. Below a group is named as, *‘solution to wellness’*, (PN10), the name of this intervention. In the speech of the participant it is difficult to distinguish whether the signifier is *too* or *to* suggesting an ambivalent nomenclature allowing the activity to be unconsciously directed towards preventing rather than promoting recovery.

7.3 Psychoanalytic Formulation: Transference and Groups

Diagram 5 Psychoanalytic Formulation Transference and Groups



This section evidences the transition from individual to group psychology and the unconscious powerful influence of the group on the individual. The desire to belong influences how individuals relate to the Other, resulting in a preference for group cohesion over therapeutic work. Identification and contagion are examined. Unconscious male and female positions exposed in transference and group behaviour are identified. The importance of an ego ideal for the group necessitates analysis of the role of the leader. Consequently data in this section precedes and relates to the final formulation identified as transference and leaders.

7.3.1 Identification and contagion

There is a hypnotic aspect to a group which gives sentiments and acts a contagious quality, causing individuals to give up personal positions for group consensus and cohesion. In an earlier example all but one member of the group identified with a sentiment that it would be advantageous if a patient followed a previous pattern of emigration. This happened by the direct induction of emotion via the primitive sympathetic response similar to elements of contagion that occurs in the infant undifferentiated from the (m)Other. Group members identified with anOther who

expresses the desire that the patient emigrates. The Other embodied in the role of group leader is a powerful authoritarian specular image. Through identification the group share some of the Other's power and authority, protecting their position, enabling them to do something that is otherwise impossible, a repetition of the organising principles of childhood. This positive and necessary part of childhood development can in adulthood have a positive or negative quality.

Joining a group results in a shift from individual cultured behaviour to actions dictated by instinct (Freud, 1921a). The unconscious descent into barbaric behaviour emerges and the more intelligent in the group are obstructed in their efforts because an intensification of affect occur creating conditions unfavourable to good intellectual work. Interview data identified cultural conditions standing directly in the way of good intellectual work;

'Going back to the 60's and 70's prominent psychiatrists at that time used diagnosis as a very broad kind of Geiger counter and to describe the individual symptomology in relation to the individual's life, as in a personal experience that has to be the way to go to help the person to deal with those things. But that has been kind of brushed aside in favour of the more simple but less effective diagnosis/medication kind of thinking which is very simplistic. It means that sophisticated thinking or consideration is sometimes sneered at, sometimes seen as being unnecessary or kind of overly complex for the sake of it' (PN5).

Via transference, the group opt for simplistic less effective thinking, descending several rungs in relation to case conceptualisation and formulation, remaining dependant. Thinking focuses around the lowest common denominator and a medicalised model founded on observation and categorisation. The period of the 60's/70's was more aligned to recognition of individual symptomology by psychiatrists. Reductionist science has been applied to the patient and is supported by the dependency behaviour of the group supporting Verhaeghe (Verhaeghe, 2004) argument that the plea for a scientific approach in psychiatry resulted in the creation of the DSMIV. Complex unconscious formulations are avoided allowing group members to achieve belongingness sustained by a leader with power transmitted through a master discourse. Nonparticipation in the group's accepted model is viewed as suspicious and subversive, dissention is obstructed via intensification of affect.

Additional data supports the failure of the reductionist approach and the maintenance of the master discourse;

‘I see a psychologist every Thursday morning, for an hour.... The doctor decided that he couldn’t really understand what was making me feel depressed so I was able to talk to the psychologist about how I am really feeling and what makes me feel the way I am feeling and hopefully that will work. Like the psychologist will help me cope better with my illness and my feelings’ (PN9).

Individuals are unconsciously intimidated by group power;

‘Their mental activity is bound and there is a lowering in individuals of a sense of responsibility for the work’ (Freud, 1921a)p85.

In the former example responsibility has been handed to the leader, having a powerful negative effect on the ethics of the majority of group. In the latter example the leader failed but retains power over the treatment. The participant remains bound by transference retaining belief that the Other understands him better than he understands himself and switches transference to the psychologist. Groups are impulsive changeable and irritable and the feelings of a group are always very simple and very exaggerated (Freud, 1921a, Bion, 1990).

‘The intellectual ability of a group is always far below that of an individual, its ethical conduct may rise as high above his as it may sink deep below it’ (Freud, 1921a)p79.

Lowering intellectual ability allows contradictory ideas to tolerably coexist without conflict arising from logical contradictions. The example above epitomises the group’s shift in emotions and ethical standards alongside identification with the leader.

7.3.2 Identification and the ego ideal

The leader becomes and is maintained as ego ideal through unconscious identification. In a regressive manner it is a substitute for a libidinal link to the object, the process of introjection of the object into the ego which may stem from a perception of a common quality in another who is not an object of the sexual instinct. Members develop a mutual tie based on an important emotional common quality

located in the link with the leader that they can relate or aspire to. The common quality is located in the power to diagnose and prescribe, he is a subject supposed to know in the institution and society. Identification gives members a share in power defending them against anxiety provoked by patients, enabling reduction of the patient from subject to object and the social construct around the leader becomes the norm.

‘You reduce their personhood to a diagnostic problem and everything gets sucked into the explanatory power of that and it is enormously powerful and you end up finding people behaving in ways that they wouldn’t do in any other context. It is really quite astonishing. It swings almost completely to the opposite direction where you have people being talked at in very, very disrespectful kinds of ways. Ways that you would not speak to someone at a party, in a café. Really astonishing stuff and you know there is almost like an implicit permission when you dehumanise people, to behave towards them in certain kinds of ways, it’s part of kind of institutionalisation kind of culture that sometimes dominates the mental health system’ (PN5).

Staff are complicit through engagement in apparently benign rituals that support the culture of the ego ideal and dehumanisation the patient;

‘A total of eight staff, (nurses, doctors, psychologist, and social worker), sat around a large table and the consultant took a seat at the top. Two lists were circulated with patient names, medications, key worker details, Register and a comments space. The consultant explained that following some discussion with the CNM2 they had decided to use two lists in future, one for acute patients and one for patients who were longer term with the service and did not require weekly reviews. The Consultant commented on the volume of paper being used and our responsibility to the rain forests. He returned to this discussion at the end of the meeting and it was one of the few times that most of the group contributed to discussion, debating word processing methods that would allow them to use as little paper as possible. The meeting followed a format that quickly became apparent. The Consultant called out the patient’s name and various members of staff responded about their current condition and events considered noteworthy since the last meeting. The meeting had a question and answers quality with the consultant asking questions about case progress to specific team members. There were rarely interjections from other team members and little debate. Questions were closed in nature; Does she feel better? Does she look better? How is she spending her time? What is she concerned about?’ (FN1).

The lists reduced patients to three signifiers, name, medication, diagnosis, fulfilling the leader position of subject supposed to know, with three markers and specific questions, minimising space for discussion and challenge to leadership on treatment decisions. The dehumanising process, reduction of *'personhood to a diagnostic problem'* (PN5) is a powerful tool in sustaining the group and maintaining the leader. Everyone is held in place and the only open discussion centres on environmental concerns and introducing efficiency by further reducing inscriptions about patients. The reduction to three signifiers places the patient in the register of the imaginary. Decision about two lists shared between consultant and CNM2 indicates a special identification that has taken place and discussion about rain forests indicates that when the conversation moves from diagnosis and medication, the rules about participation changes. The name remains as the only original symbolic marker connecting patient, intervention and unconscious, which is resisted by the group to maintain the status quo;

'People are discussed in terms of diagnosis and medication instead of their problems, their difficulties, their individualised – ahm – the individual structure of their internal worlds, the sophistication and complexity of that is usually ignored – ahm - certainly at team discussions anyway. It's ignored and it's never opened up for any kind of open consideration. This is not consistent with any kind of best practice' (PN5).

The group, having introjected the leader as ideal, require divided egos in which the two parts can war against each other. The split off part contains the object or part object that has been introjected and the critical element of the ego comes into conflict with the ego ideal. The ego ideal is the main influence in repression and in narcissism allowing satisfaction through the ideal when disappointed with the ego's inability to meet external challenges. Finding satisfaction in the ideal when the ego fails to meet a challenge, maintains the sense of alienation and the position of the ego ideal as containing some quality of a messiah, sustaining us when we are severally provoked. Earlier there is an example of the staff being severally provoked by the patient and provoked by the challenge from one member unready to introject the leader as ideal. The internal conflict between ego and ego ideal is acted out in the external squabble between staff in relation to roles, responsibilities and issues such as timekeeping.

The data provides evidence of the unconscious desire to remove challenges to the leader and to protect the ideal. Overwhelming anxiety experienced when confronted with the Real, particularly when appropriate defences are undeveloped, leads to unhelpful contagion and identification. Regression occurs when partially contained anxiety through identification with another emerges, allowing individuals to believe they can operate in the same manner as another member. The member who stands outside of this identification is a cause of conflict, an unwelcome challenge to both group and leader;

‘If I was doing it differently I would just have medical and nursing and then refer to the necessary disciplines’ (PN6).

Warding off of challenge in relation to the ego ideal is acted out in team conflict and sometimes credited towards a safety in numbers theory;

‘The kind of hospitalised structure of things keeps the medicalised professions in numerical ascendancy so that if there is simply ten people at a meeting and eight of them are doctors and nurses its naturally going to be biased towards that kind of training that those people come with and its not to say anything negative about those things individually but it means that the system and therefore peoples experiences in the system are heavily biased in a particular direction’ (PN5).

Freud does not subscribe to group size as the factor enabling the emergence of unconscious behaviour, preferring the mechanisms of identification and contagion as causal, these findings support Freud’s position. The untenable position of identification with a single model of mental health requires bolstering and one option left to support the model is sustaining a critical mass of supporters, medical and nursing staff, as foot soldiers even when faced with direct criticism;

‘I think there should be more counselling services and more psychology services’ (PN9).

Using a critical mass of supporters to maintain a position is unsustainable in the current climate of change as expounded in a *Vision for Change* (Government of Ireland, 2006). Without a critical mass the alternative is to use the defence

mechanism - denial - and claim that structures are now vastly different from a previous era;

‘Whereas years ago, I keep going back to years ago, I feel like I am a hundred years old. Years ago you just sat in and there was the doctor, the old style consultant there and all the rest of us and nobody opened their mouths at those meetings. I remember as a student nurse, you never made, they would ask you, when you go in; ‘Did they sleep?’ But you would never ask the patient a question in the meeting or you would never comment on or add anything to it. During it you answered whatever questions you were asked and that was all you did. Now everyone takes part in the meeting and I think the patients are more informed of it now but not one hundred percent’ (PN2).

This is a complete contrast to what was observed in MDT meetings, beliefs do not match what is observable; the ability to maintain a divided ego enables this contradiction. Additional observations support the Freudian position;

‘Outside the window in the observation area there is a male patient pacing back and forth. Occasional he talks to himself as if he is responding to a voice he hears. He also makes unusual gestures with his hands, he appears distressed. This behaviour is consistent for the hour I spend in the office. There are two student nurses on the unit a male and a female. They are on their first placement in a mental health service and do not appear to be engaged in any specific activity. The female student came into the office and left again to wander up and down outside the office. The male student nurse was also wandering back and forth outside the office. At one point the male student came and stood outside the door looking into the office in the same manner I had noted some of the patients doing. He then paced around the observation area mimicking the gestures and movements of the patient I had noticed pacing in this area’ (FN2).

The pacing patient receives no staff acknowledgement. He appears to be hallucinating; he frequently looks at staff and makes eye contact with the researcher occasionally. He is noticed by the male student who appears equally lost and whose mimicking also appears unnoticed. This incident questions the organisation of learning for students. The mirroring indicates identification with the specular image of the patient and transference and association between the two. Observations of pacing and standing about without any clear intent by staff, students and patients were repeated on a number of occasions. There is also something unspeakable happening, ‘something un-representable can be interpreted as points of encounter with the Real,

and this is the closest we can speak of something ‘outside discourse’ (Parker, 2005a)p176.

Students’ presence is not always welcome;

‘A staff nurse and two students from the patient activity area came into the nurse’s office on the FAU. The students appeared at a loss as to what to do and stood just inside the door with their arms folded. ‘Were you here yesterday – do you know the board?’ ‘Yes’ ‘we come up here every day to get a report on who is suitable they also have to be in their day clothes to come down’ (FN1).

The students additional to the staff compliment trailed behind their mentor at a loss about engagement with staff and staff appeared to have little to communicate to them. Students are not always viewed as having this surplus quality particularly when the unit is busy;

‘When you don’t have enough staff then usually it’s the time with the patients that suffers because you basically try to prioritise, and during that prioritising there is a doctor in the office, and there is no way you can say wait here I want to go outside and speak to a patient. So this is the problem with the staffing, the patients suffer, but any way it’s obviously helpful when you have got students because at least they take the pressure off, they have the time with the patients and they can talk to the patients, that’s the time that is very helpful’ (PN4).

Student’s value is spending time talking to patients. Observations of students mirroring patient’s distress or engaging in household tasks gives scant reason to believe that students, who have time will have ability to engage in therapeutic or even social conversation with patients. Additionally students identify with qualified staff indicating that in the future they are more likely to prioritise doctors rather than patient’s needs;

‘We don’t have enough resources really and it is terrible now what is happening with nursing, because we have lost one nurse. One has been transferred off the team to another place, another one in September is going on an extended educational leave, travelling basically, and a third one will be retired and we have been told that there is no real prospect, certainly no guarantee that any of them will be replaced. So what are the people going to do here? Well its only three members but you have just eliminated everyone except the nurse manager. Everyone else that can work in the day hospital will be gone so the nursing situation is critical’ (PN8).

Valuing nurses' direct contact with patients is identified above. However, participants identified difficulty for nursing relating to their traditional system management role, noting nurses had difficulty being part of the team concerned with change as they had to answer to an offsite manager who took ownership of the physical environment, so territorial issues such as office allocation had to be sanctioned by nursing management, emphasising ambivalence between nursing and other professionals. Nurses believe that they spend the most time with patients and see this alone as meriting reward. Their repertoire did not extend beyond *'listening'* and *'reassuring'* as an expression of the importance of this time, instead focusing on their 24/7 all seeing presence as a marker for therapeutic worth;

'Even if they don't want to they are left with no choice because we see them 24/7. We are the ones that see everything that happens but you do get the odd Doctor who obviously does not want to listen, but usually the communication is great' (PN4).

Limited interaction between patients and nurses was recorded and supported by interviews; staff attributing it to system failure and staff shortages, a position somewhat supported by patients;

'I can't complain about the staff. The staff are first class and they do their best but, you know what I mean, they have constraints as well. Where, you know what I mean, there is a freeze on by the HSE, staff been taken off you know and I find that disgraceful more should be done' (PN9).

'I spent one hour sitting in the male admission unit day room. After ten minutes a uniformed nurse came in, she had a mobile phone in her hand, she walked between two chairs where patients were seated went to the door that lead to the garden looked out and then left the room. She did not speak to anyone or appear to notice my presence. Thirty five minutes later a male nurse came in, he spoke loudly commenting that it was budget day. He sat with a patient and asked him how he was, had he seen the doctor today and when was he going home. The conversation was pleasant and loud enough for everyone to hear. He turned around and noticed I was in the room and said 'Oh Gerry, there you are.' He then stood up and went over to where two other patients were sitting, they had been talking earlier. He commented to one of them that it was good to see that he was now talking and said 'you were not talking the last few days, put that behind you, do not go back to that.' He then announced to the room that it was dinner time, everyone got up and left' (FN1).

During this observation hour six patients and two staff members spent time in the day room. One staff did not speak to or acknowledge the patients with her gaze. The second staff did engage two different patients in brief conversation which included acknowledgement that one had given up his symptom of silence. The data demonstrates repetitions of casual infrequent interactions between staff and patients that deny the claim;

‘We are the ones that see everything that happens’ (PN4).

Identification and contagion is not necessarily spontaneous and participants struggled with the influence of institutional transference. This struggle observed in the transition between individual and group psychology and differentiation between basic assumption and working groups, categories is described by Menzies Lyth, (Menzies Lyth, 1988, Menzies Lyth, 1989) as the dynamic of the social.

7.3.3 Transition between individual and group psychology

Participants are socialised into patterns of thoughts, beliefs and behaviour that are incongruent with personal beliefs;

‘What does it say to a student when they come in – you come in to change the world and go very quickly to - I personally found this – am I ever going to make such a difference? And a group of us were talking a couple of weeks ago, will we when we qualify ever do anything? Do we have an actual difference to make? ‘I have made a conscious effort in this place to sit down because it is very easy in this place to jump on the band wagon with all the other staff- because we are young we are out to impress- we kind of – there is a tendency to be influenced but maybe for me to liken myself to them and to do what they do and that not necessarily is always right and it does – it just seems that there is less and less people actually out on the floor as such sitting down and doing the basics of psychiatric nursing’ (PN7).

This ethical dilemma wanting to belong equating to lowering personal standards is troublesome. Retaining standards bring the perception of not fitting in demonstrating the powerful effect the group has on the ethics of the individual (Freud, 1921a). This participant could take comfort from the comment below on being ***‘run off their feet’*** business and the evidence above relating to staff activity, namely appearing busy, as a defence against anxiety suggesting that the symptom – busyness – represents avoiding engagement with patients.

‘The nurses do give you time to talk to but not a lot because there is oh so few of them and there is so many patients they can’t just take us they couldn’t they would be under resourced to do that. You could not ask them they are run off their feet very, very busy and they still have time to say hello and have an exchange with you – a few remarks here and a word of comfort there you know. I have seen great changes – a change from the interaction of the nurses with the patients. They are more on the computer now. They do marvellous work and I guess it is not up to the hospital to engage in conversation with the patients it’s up to them when they are diagnosed or whatever. It is up to the clinics or day hospitals or the places afterwards’ (PN1).

Dismissal of the function of hospital staff to engage with patients mirrors PN7’s fear that he will not engage, confirming the perception that hospital staff do not have a role in engagement; patients are maintained as objects expressed in the group belief;

‘...it is only when the medication kicks in, as a psychiatric nurse we will refer them on, and say listen you are doing – well, but not because I have had an impact on the person’s life’ (PN7).

No evidence supports the theory that psychical interventions by hospital based staff should not take place however the idea of onward referral was as prevalent in the day hospital;

‘Psychology should come once they are well, for when they are finished their stint in the day hospital’ (PN6).

Warding off engagement is supported by occupants’ actions and beliefs which place psychological intervention as something that should occur when the patient is well. Limiting engagement with the patient and the desire to limit the staff group to two professions, demonstrates the existence of a dependency group operation as if paring is the desirable position, enabling avoidance of reality and maintaining a closed system. The traditional asylum is physically and psychologically closed and permutated with negative expression of its value as a therapeutic environment;

‘In the hospital there is nothing there is only therapy¹⁶ and there is no medical input like you don’t have professionals in the hospital like psychologists or anything like that you know, and in the hospital there is nothing there whereas I think there should be’ (PN9).

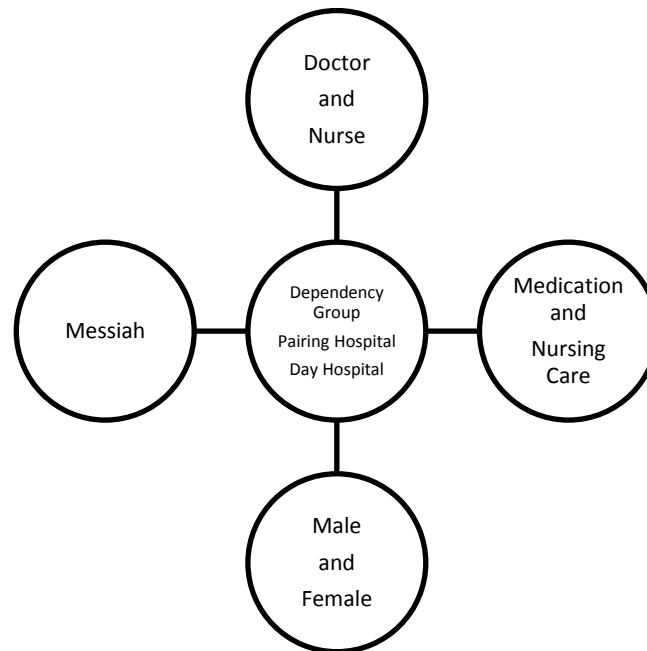
¹⁶ Reference to the patient activity area which provided group occupational activities

‘I remember saying to someone once I wouldn’t, I wouldn’t allow one of my family members to come into the mental health service. I just wouldn’t I would be worried about their welfare, not only because I wouldn’t believe they would receive all of the care they need but they would be actually damaged by the experience and this is the very worrying thing in some ways that people are actually damaged, their rights are violated, this is common knowledge, (PN5).

‘Experience is a huge thing, understanding of an illness. I have seen staff who do not understand mental illness or don’t have an empathy towards people therefore they feel that it is all put on or drug related or there are biases for want of a better word’ (PN2).

Despite the removal of walls, reforming legislation and shifting to a community base the closed system remains. The unconscious tolerates paradox; ambivalence allows contradictory positions to coexist. Traditional roles of male and female are represented by the medical and nursing professions, strengthening the unconscious group dynamic of pairing. The administration of a medical cure supplied by the messiah dominant over psychological interventions, remains in the prescription of medication the exclusive remit of the phallic Doctor, the leader supported by the law (Government of Ireland, 2001a). This is not quite true as nurse prescribing was introduced into the Irish health care system in 2006 (An bord Altranis, 2012) however no evidence of it was found during data collection. Notably the system of nurse prescribing allows nurses to prescribe only in the context of a supervisory relationship with doctors, under agreed parameters. Nurse prescribing as introduced retains power with the paired professions.

Diagram 6 Unconscious influences on staff decision making



Group membership provides protection while simultaneously keeps the patient at bay this is recognised but unaddressed by staff managing MDT meetings;

‘It should be an optional thing; they should not have to go into that. I wouldn’t like it. People feel they are going to be analysed. You are not going to be yourself, be open; it’s hard to have a proper relationship with a group as opposed to an individual. Over the years I have had very few people complain, but a lot of that is I think they have no choice. ... If I was anxious depressed or paranoid I imagine it would be horrific and no one is forced in but sometimes feel they do not have the choice’ (PN2).

Participants acknowledge the group’s powerful effect, enabling staff to promote the system regardless of potential damage to patients through negated choices resulting in an unstated, unrecognised opportunity for staff to violate individual’s rights. Group compliance enables the lowering of ethical and moral behaviour which individual’s find unacceptable.

7.3.4 Male and Female positions

Unconscious polarised male and female positions leads to rivalry between staff and patients for the doctor's attention, an oedipal struggle between nurse/mother and patient/child battling for the doctor/father. This battle to be the object of desire is destructive enabling powerful negative transference to dominate relationships. It is expressed in the nurse's desire to be supported and protected by the doctor and in the doctor's rejection of this libidinal attachment;

'She (the patient) just barges into the office and even when her consultant is here, he doesn't say anything, he doesn't say 'go out and you shouldn't be talking to them like that' (PN10).

The rivalry that dominates the oedipal stage and the desire to be the desire of the Other supports the data relating to narcissism and mental health. The doctor is required to apply the law of the father, ***'go out and you shouldn't be talking to them like that'***, to keep the mother as object of desire. He refuses and tolerates the patients demand for attention provoking rivalry. Patient's participating in rivalry with the nurse will be subjected to intense feelings of hatred and identified as subversive and dangerous. The narcissistic injury, the failure of the doctor to maintain the nurse as object of desire, drives her to rejection of the ego ideal leaving two alternate choices. Libidinal attachment could be transferred to the patient via the imaginary indispensable quality of nursing through the adoption of a parental style of care, fostering dependence at the level of (m)Other for the needy demanding patient/child/rival. The patient is required to but does not always cooperate with this, instead they struggle to assert individuality through rivalry;

'She knows there is no consequences. We have tried behavioural charts, we showed her the boundaries of the ward and everything, but she keeps throwing it back in our face, that she can't be thrown out, that nothing can be done you know' (PN10).

A behavioural based boundary setting symptomatic approach akin to toddler taming, is a direct transference response to the unconscious battle being fought and poorly lost by the nursing protagonist. Conceding defeat requires giving up being desired which is intolerable, therefore additional sufficient opportunity for staff to force jouissance

from the event are sought through the alternative solution replacing one leader with another, recourse to nursing and administrative management;

‘We had a case conference yesterday on her and one of our Directors of Nursing was there, and she actually said that she is afraid that one of the patients or staff will be maimed or seriously injured’ (PN10).

If this alternative ego ideal fails, additional parties are on standby to continue the battle and take on the mantle of subject supposed to know, the law and ego ideal;

‘That is what we all feel, she should, and they are hoping to get her to St X’s to Unit Z, the locked ward. We have Dr Y., coming out on Monday to assess her, so she is coming out on Monday hopefully to assess her but it is actually so serious that they are going further now. They are getting Mr A., (Administrator) involved if Dr Y says no, you know that’s how serious it is’ (PN10).

Bion (Bion, 1990) identified that failure of the leader in a basic assumption group to satisfy the group, results in prompt disposed of and replaced with an alternative who will eventually suffer the same faith. This process protects everyone involved as when all alternatives have failed or the assigned task is fulfilled, the original leader will be reinstated and the group dynamic re-established. This chain of alternate leaders is augmented by language employed in discussing this critical aspect of care, *‘That is what we all feel’*. Group power is evoked to sustain and support the position that the troublesome patient should be dismissed.

Adoption of male and female positions is also evidenced in perception of patient activities;

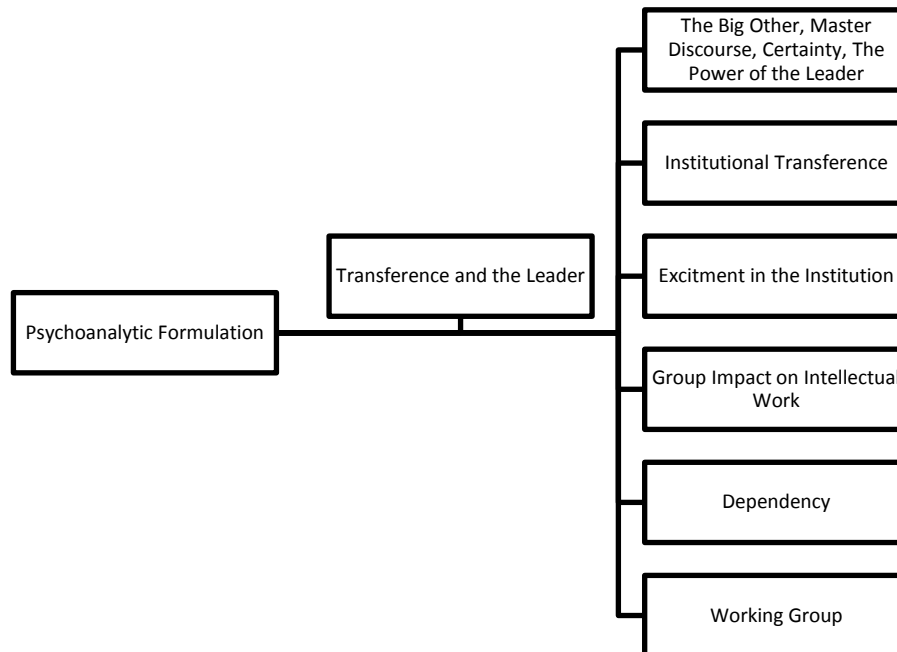
‘She is absolutely brilliant very enthusiastic. She has groups for –aha-solution too wellness, it’s mostly women’s groups now at the minute because there is no male down there to guide us as to what males would actually want to talk about you know. But she does discharge planning, medication management all things kind of relevant to the women here’ (PN10).

There is failure to recognise that regardless of gender people may require similar activities. The identification of the absence of *‘a male down there to guide us’* emphasises staff polarised position. Males and females work in services, physical

lack is not the issue; males are established differently to their female counterparts. Female distinguish themselves by wearing uniforms while males adopt a relaxed dress code. Male and female students wear uniforms suggesting unqualified males have yet to achieve a rite of passage to a full male identity and are more akin to their female counterparts. The observations and connections of the transition between individual and group psychology and male and female positions evidenced lead to exploration of transference and the leader.

7.4 Psychoanalytic Formulation: Transference and the Leader

Diagram 7 Psychoanalytic Formulation Transference and the Leader



This section explores data relating to transference in the subject-Other relationship with a particular emphasis on transference relating to the Leader. Findings include evidence of transference towards a Big Other, the influence of the master discourse and power in relationships. Inevitably the Doctor is identified as the Leader by participants, resulting in an exploration of this role; however evidence also emerged on transference to nebulous structures such as the institution and the law which are examined. A percentage of the data relating to the leader includes his relationship to the group.

7.4.1 The big Other, Master Discourse, certainty, the power of the leader

Data presented has exposed the shutting down of opportunities for patients to engage in therapeutic discourse. Participants spoke about the value of talking therapy and its relation to personal beliefs and the power of leaders. The welcomed opportunity to speak, contrasted sharply with previous experiences and highlighted different beliefs held between hospital and community care;

'I was frightened to talk, I could not find a beginning, it was so tangled I was talking in reams'. 'I relied mostly on the nurses, I was scared of doctors because they had the power – do you want to go in or we will sign you in – nurses I was a bit scared of too – being feminine they could calm you' (PN1).

This extended to anxiety relating to the power held by staff over patients;

'I would not trust anyone at all to understand to know me- I was afraid of myself and the power in my head – I was afraid of everything – I was afraid of people out there- people in the community – I was afraid of the doctors I felt I would be locked up if they only knew – in actual fact at one stage, to one of the doctors I said, if you only knew what was in my head in my thoughts you would lock the door and throw away the key' I don't believe in it anymore', (long-stay care), (PN1).

This expression of anxiety that the doctor could exert the power of detention and treatment if the patient was uncooperative was a common theme;

'People are over medicated, their kind of the chemical strait jacket idea is kind of the prominent one, people are in my view bullied, harassed constrained psychologically and emotionally and treated in a dehumanising kind of a way and it's kind of part of the kind of problem when you kind of conceptualise some of that being a medical difficulty and it's that person that you are actually dealing with' (PN5).

'There are lots of physical symptoms from depression and from the medication and some of them are - ah – they are excruciating. Seriously ya, your vision gets blurred; your dry mouth and you might feel dizzy weak you know. Your muscles tense and all that like you know. Some of the side effects are desperate like you know. They can be very uncomfortable. I would seek medical advice and the Doctor would say 'if its keeping you well just put up with the side effects and they will wear away,' like you know sometimes they would and sometimes they wouldn't' (PN9).

The patient suffers the side effects as a cost of trusting the doctor's prescribing. The cure is unsatisfactory, yet investment in the ego ideal of the doctor enables acceptance the *'put up with'* discomfort. This is the price extracted from the subject for the attention of the Other. Faith is retained by creating and maintaining distance between doctor and patient, by the creation of illusion about how the work of the institution is conducted;

‘They (Nurses) would assess you and they see how serious your condition is and they would take your clothes off you and you would be assessed by the nurses’ on-going. They would assess you, write up notes and give it to the Doctor. The Doctor would go according to what the staff, the psychiatric nurses, would say in the notes and they would review you and would ask you how you were feeling and if they felt that you were a risk to yourself they would keep you in the hospital’ (PN9).

The imaginary system described is staff cooperating in developing a treatment plan with the doctor’s input mediated through nurses’ symbolic inscriptions. This fiction is contradicted by evidence that nurses suggestions go unheeded and the observed lack of nursing language to contribute to the decision making process. Additionally as identified above, the doctor is a leader at the mercy of a dependency group constantly failing as the ego ideal for nurses, his failure to listen leaves staff dissatisfied with the extent of his power and control over the clinical area. The unconsciously ascribed male position allows the doctor to demand satisfaction from his nurses;

‘We have no control at all. We are actually told by the consultant who is coming in or if we even know the patient we would know that when they come in here they cause trouble or they need to be discharged or whatever. Sometimes the doctors don’t listen to us at all even though we would say; say X said she is not to be admitted the next time she comes. They don’t listen and she is admitted. The same trouble happens again and then she is discharged you know. So you know it would save an awful lot of resources if they did listen to the ground floor kind of, but we would have no control over anything that happens really’ (PN10).

Contrary positions exist, patients believe, nurses’ speech influences doctor’s decisions while nurses argue that they are unheeded and that doctors display a compulsion to repeat the symptom of multiple readmissions. The system facilitates the doctor as leader regardless of patient and staff needs. For example weekly MDT meetings are scheduled but were occasionally cancelled or prematurely terminated due to absent consultants. Consultants acknowledged this and it went unquestioned by others;

‘You have picked a very bad morning to come. I have a tribunal at 10.30’ (FN10).

This displays ‘plus de jouir’, the doctor can afford to cancel at short notice with no apparent regard for the effect this had on others contributing to their voiceless status.

Being alone and voiceless, having no one to address displayed the power of the leader and the importance of an alternative approach;

‘Dr X was good with prescriptions but he didn’t encourage talk... Dr Y took me on – he encouraged me to talk – he said I was holding back- I couldn’t start. Then I had psychoanalysis and psychotherapy I could not stop talking I talked and talked – 57 years of not talking to anyone’ (PN1).

Data reveals participant feelings about combined treatments making a significant difference and enabling recovery, a contrast to the fear generated by services;

‘I knew nothing about psychiatry, all I knew was Dundrum¹⁷, was a mental hospital what do they call it oh I forget. Dundrum was behind locked doors, big, big walls; you were locked away in cells, that’s all I knew about it’ (PN1).

These contributions combine key issues of overwhelming anxiety that the leader can annihilate you alongside acknowledgement that the threatening system is also capable of restoring you when a change in the treatment regime is introduced, the opportunity to engage in therapeutic talk. Akin to infant’s anxiety of a good or bad (m)other, the leader, embodied in the flesh of the doctor has the power to detain and control or release and support, at once a good and bad object, a master with a dominant model of care who must be obeyed;

‘The mental health services are deficit massively in critical areas of care, primarily psychological and psychotherapeutic. Maybe a little bit more broadly psychosocial and this seems to be a part of the sort of dominance of the medical care’ (PN5).

Descriptions of early experience of mental health care and fear of speaking shows participants as alienated from the system supposed to help. Language permits the coming into being of desire and concurrently frustrates its expression. The child expresses itself through the language of the (m)Other entering a lifelong struggle marked by representation of the self in words. Articulating the self carries risk;

¹⁷ Central Mental Hospital for the treatment of court and prison referrals

‘If you only knew what was in my head in my thoughts you would lock the door and throw away the key’ (PN1).

When nurses have no language or unconsciously choose silence, patients are doubly condemned to a voiceless existence.

In Lacan’s formula for the master’s discourse, the master must be obeyed, not because we would all be better off that way or for some other rationale, but because he or she says so (Fink, 1995a). The requirement to obey the master regardless of individual belief, extends beyond the clinical setting to state bodies responsible for the quality and style of service delivery;

‘We can be positive or negative about the Mental Health Commission but it has defiantly got us on our toes and making sure we are getting our work done and improving the service provided’ (PN2).

The master is in a position to address the slave who works for and produces something in terms of knowledge for the master;

‘Your heart would go out to people that need to talk to someone and they would absolutely know nothing and there is no one available for them to talk to – even just to talk to’ (PN8).

‘It’s very difficult; it’s very tough you know. You feel people don’t want to know like, you know and that’s why, God love them, people take their own lives because they can’t handle the situation and people can’t help them because some can’t talk, you know they find it very difficult. They feel they are very different from everyone else’ (PN9).

The master is disinterested in the subject’s difficulties, his concern is continuance of the system. The subject’s produce has a surplus quality a ‘plus de jouir’ for the master. There is a physical excess of patients and consequently a psychical excess of symptoms and opportunities for transference allowing staff to pick and choose patients for admission;

‘This sounds terrible, not the neurotic side, there are people here who are very genuine and need a lot of help. The service is overused. I think there are people who should not come in to hospital it’s not beneficial to their health. I know some people like being in. Sometimes the hospital thing causes more harm than good’ (PN2).

‘Some get very institutionalised it’s like as if, we used to laugh about it, as if they are texting each other; ‘I am after taking an overdose in hospital’, because next thing they will all be in. The same little group and it’s from the same area again’ (PN10).

Patients are presented as coordinating their admissions, their behaviour and numbers are considered excessive and negative transference is generated particularly in relation to patients with similar presenting features. The model of observation and categorisation has a rebound negative effect. With negative transference and excess patients, staff are enabled to maintain their position dismissing the level of distress experienced by individuals;

‘Sometimes people go to the hospital and they are not admitted, you know they are not taken seriously by the doctors and I think this is absolutely disgraceful’ (PN9).

An alternative interpretation to the above quote favours the medical position; the doctor charged with diagnosis and treating has limited resources at his disposal and is compelled to make clinical judgements on resource allocation. However ***‘not been taken seriously’*** reflects a power imbalance and failure to avail of alternative therapeutic approaches;

‘It is very rare that someone comes into the mental health service and would have a psychological or psychotherapeutic experience’ (PN5).

This suggests that the doctor like the father in Freud’s primal horde keeps it all for himself. Participant experience of talking therapy and a positive sense of the doctor is a secondary experience, a new master discourse occurring at the introduction of a new regime, via the *Mental Health Act* (Government of Ireland, 2001a) and *Vision for Change* (Government of Ireland, 2006). The doctor as legislated leader of this new regime retains receipt of patient pathology on which to base service development and requires no consideration of analytic discourse.

Perceptions about the value or purpose of talking with patients are viewed differently across professional groups with some understanding it as an opportunity to gather

information for the doctor's diagnosis augmented with the false belief that information gathering is a psychotherapeutic process;

'All the staff are down there (activity area) talking to the patients because that is where they divulge what is going on in their lives you know. Sitting at the bed for a few minutes is not enough so really the hour or two, even sometimes we just bring them for a walk around the grounds and they don't realise they are talking to you when they are going around because they are just sharing experiences' (PN10).

These contributions from participants, (PN1, PN5, PN9 & PN10), illuminate contradictory beliefs. Beliefs about speech between patients and staff range from it being a dangerous process resulting in detention, to information gathering to aid diagnosis or a process conducted by stealth in which patients under the parental gaze disclose. Participant discourse on the purpose of verbal interaction fails to recognise and utilise transference in an advantageous manner, excluding discourse from *'psychotherapeutic experience'* (PN5), demonstrating total denial of analytic discourse.

Where an ego ideal is required and negative transference abounds, it becomes overwhelming to constantly attach excess negative transference to the doctor. In the excerpt below the doctor is not as clearly identifiable as the subject supposed to know in relation to his power to prescribe for the patient;

'In regards to medication you are tried on so many different medications. I understand with the doctors it's trial and error but there are so many chemicals going into your body you know and the side-effects, you know. So many chemicals, I think there should be more therapy used instead of medication. More talking and that you know one to one you know. Where medication can only do so much you have to do the rest but you need help, you need help so you need more medical help, more professional help, psychologists, counsellors, psychotherapists, you need more of that like more of an input of that instead of just being given medication, taking a load of chemicals and getting so many side effects whereas it affects you physically you know' (PN9).

The participant suggests alternatives to medical staff as ego ideal towards which a positive transference could be directed, an alternative object to contain and negate some negative unconscious beliefs. When this is required and no suitable ego ideal

can be identified, a quantity of negative transference is split off and given to the institution;

‘I have seen great changes – a change from the interaction of the nurses with the patients. They are more on the computer now. They do marvellous work and I guess it is not up to the hospital to engage in conversation with the patients it’s up to them when they are diagnosed or whatever’ (PN1).

This evidences conflict relating to the unconscious image of the nurse; unable to contain the quantity of negative transference it is split off and attached to the institution a place of potential indefinite detention. Criticism of the power of the leader appears as repetitions perpetuated by the system;

‘What we are working in is a self-propagating system that has no place in a modern world. We are regularly compared internationally as being you know so far out of date and out of touch with what is considered international best practice, our own best practice standards, we are far away from it. There are so many things that keep going, you know you kind of get to such a dominant thing in society. It’s given money status and power way beyond its utility in mental health and it’s the bizarre transposition of, you know, if you are talking about neurosurgery. The neurosurgeon is always the most important guy in the room, he knows more than everyone else there, he has more expertise and everyone else is there to feed into his role. That doesn’t work in mental health but that system is transported onto it so you have the bizarre scenario where the consultant who won’t know as much as a clinical psychologist for example about a treatment format but the consultant has all the power which means that there is a kind of a, at least a lot of power imbalance that shouldn’t be there. Mental health is a much more complex system’ (PN5).

This form of criticism extends to other staff in positions of power and allows staff additional directions for the projection of negative transference;

‘I thinks there seems to be an awful lot in offices, whereas, if they ever heard me, if half of them came out of the office I don’t think we would be as short staffed as we are you know. There seems to be an awful lot of managers around and there is a lack of communication in the office as well a lot of the time. Whereas you pass on a message and then the next day you come in. When you come in the next day then you could be attacked on the phone where someone wasn’t told what was going on, on the ward. You know that kind of thing’ (PN10).

Negative transference directed to managers results from regression to infantile responses to the Other. *'You could be attacked on the phone'* (PN10) is projection of internal bad affects onto an external source alongside the introjection of good affects. Participants draw clear distinctions between ward based staff doing good work in difficult circumstances, looking after the children, while the Other with the power to reward or punish their endeavours remains closeted in an office.

'Consultant; 'Gerry is writing furiously isn't this juicy this is just what he wants.' (laugh most people join in)
Psychologist 'We need to make sure that if someone is in therapy this does not happen'' (FN4).

Staff had expressed disagreement about an approach to a patient; the consultant took the opportunity to assert his authority stating that others did not fully understand psychiatry or the medical model and to make an apparent random comment about time keeping. Everyone had arrived punctually to the meeting unlike two previous occasions when some staff were late. The challenge about an approach to care by the psychologist was diverted to time keeping by the consultant; it was unresolved, and;

When the meeting concluded and staff began to leave the Consultant engaged the Social Worker in a conversation about lateness to the meeting. The Consultant jokingly asked had he been up all night watching the results of the election' (FN2).

Humour was used as an attempt to redress the tension about treatment and when it failed it was displaced onto the researcher. Within the MDT to cover up the tension my presence and *'furious'* note taking was commented on. The fury relating to the challenge about power and control is projected onto the researcher displaying the contrast between MDT meetings in hospital and community services where the former were less threatening for medics as their power base is securely established.

7.4.2 Institutional Transference

The hospital takes a big Other role and is the subject of powerful transferences;

'If we could sort the outside out a lot of the hospital will look after itself'
(PN2).

The benefits of hospital care and patients' abuse of the system references it as ***'the hospital thing'***. Crediting the system with unreasoned power of indefinitely physically and psychologically; ***'I felt I would be locked up if they only knew'*** (PN1), is followed by attempts to deny the attributed power; ***'I don't believe in it anyway'*** (PN1) and later attribution of significant power; ***'it's not up to the hospital to engage in conversation with the patients'*** (PN1), this positioning of the hospital not having responsibility to engage with patients is echoed by others (PN7 & PN6). ***'When the medication kicks in we will refer them on'*** (PN7) placing the responsibility with community staff. Additionally in recounting the initial experience of working in the hospital and being assaulted; ***'...it was the biggest shock, like it was welcome to the hospital as such'*** its power to punish is asserted. Participants (PN2, PN7 & PN1) identified a hospital with responsibilities and power and the negative attributes of a bad object, unresponsive to needs, silent to appeals for love, providing physical containment, a harsh inflictor of physical punishment, detention and assault.

The institution provides containment for all occupants. Rules create clear distinctions between patients and staff limiting the excitement permissible on any occasion;

'I made my presence known to the CNM2. She introduced me to another staff nurse. I explained that I was going to spend one hour in the Day Room. I was told it would not be very exciting as most of the patients were in the activity area. I said that was fine and I would be in the activity area tomorrow. It was exciting this morning we had a runner. Nothing much is happening now, in the afternoons we lock the room so people go to activities, its protected time and people can have 1:1 if they want. We are also going to have groups in the afternoons but they have not started yet' (FN1).

Locked doors, enforced attendance at activities is called ***'protected time'***, an imaginary scheduled exclusive engagement between nurse and patients in which the activity area remains open and others are not allowed access to patients, this concept was unenforced; ***'At about 15.30 a nurse came into the activity area and asked a female patient to come and meet a doctor'*** (FN1). Day rooms were accessible both mornings and afternoons and patients were frequently called from activities for unscheduled appointments. A specialised working group existed to plan activities but during the year-long data collection period, activities never moved beyond the

planning stage. This group dealt with the basic assumption allowing the working group function to proceed, effectively maintaining the status quo.

7.4.3 Excitement in the institution

The hospital's routine mismatches the imaginary structures described. Illusionary structure provides a defence against the overwhelming anxiety of engagement with patients, routine minimises stimulation creating a controlled environment limiting excitement for the occupants. Breaks to routine, exciting events, result in acting-out of unspoken transference. Staff assumed the researcher was seeking excitement while collecting data;

'It was exciting this morning we had a runner' (FN1)

'Gerry is writing furiously isn't this juicy this is just what he wants' (Laugh most people join in) (FN4).

Patients also crave and are stimulated by breaks in routine;

'There is another one coming in another patient I mean.' A middle aged woman in a dressing gown and night dress was being escorted up the corridor towards the nurse's station by four men. The security guard was walking behind the group' (FN1).

Staff attempted to control the environment by locking doors and using notices to imposed restrictions. Environmental controls are insufficient at containing excitation so staff's next option is restriction of patient numbers or balancing staff/patient ratios;

'They have the same amount of staff in Unit X as we have here, they have only fifteen patients down there, but they are different patients. They are volatile, whereas ours are actually ill at the moment; they certainly are (laugh). We are busy but it is good to be busy, we are not sitting around either' (PN10).

An agreed quantity of patients is insufficient leading to questions about the type of patient that should be admitted;

‘I actually prefer to be busy but to be more manageable if you know what I mean. There is a lot of aggression and a lot of violence on the ward at the minute. I would prefer it just to be like years ago real, real psychiatry. It’s all drug related now, an awful lot of it so you know it’s more dangerous and they are kind of more secretive and they are bringing in drugs and they have people bringing in drugs to them. And we do drug screens and its positive, then they are discharged, then they come back a few months later. It’s the same thing you know that whereas there are not the genuine schizophrenics any more’ (PN10).

Actual illness, real psychiatry and genuine schizophrenics from the past are required to satisfy staff needs.

7.4.4 Group impact on intellectual work

Data indicated a lack of intelligent thinking and failure to treat the patient as subject. The immediate reaction to the tobacco pouch incident was to transfer the patient. This reaction was challenged by a staff member with a problem solving approach enabling the patient to remove the pouch. No staff involved favoured a swift response to the request for analgesia exemplifying an approach to the patient as object rather than subject, a lowering of intellectual ability and descent into barbaric behaviour. The failure to think through a problem or question and develop solutions was repeatedly evident;

‘We do not do addiction in psychiatry.’

‘We do not have a special service in addiction in St X’s.’

‘I do not know where the addiction service is, do you?’

‘I just know the service for alcoholism Stanhope Street.’

‘I think it is Trinity Court.’

‘He said he would make contact on Friday but then he said he lost the number, (laugh)’ (FN1).

The patient as a subject is dismissed; *‘We do not do addiction in psychiatry’*, as opposed to we do not treat people with addiction. The subject is objectified by diagnosis category and dismissed by policy (Government of Ireland, 2006), allowing staff to not know available services. The patient is as object of amusement, *‘he lost the number’*, gets a laugh, the lost number is not funny, participants display anxiety, confronted by the addict they lack skills and knowledge about intervention and the certainty provided by the master medical discourse fails in providing answers. Repeatedly in formal interviews staff identified addiction, as a primary reason for admission, yet services claims not to treat addiction. Ambivalence between the real

and the imaginary resulting in staff conflicted to the point of inaction, masking their anxiety with jokes, laughing at their own failings.

Similarly staff lacked knowledge and formal routes for researching information about their primary cited intervention medication. When a lack of knowledge existed about an expired drug, no attempt was made to seek the information online or from the subject supposed to know, leaving patients vulnerable to un-quantified risk, emphasising their objectified status and a lack of intelligent thinking;

‘There were three female staff nurses, one clinical nurse manager-one and one doctor in the office all engaged in different tasks. The doctor was writing in a chart. One nurse was working on the computer rewriting the list of equipment for the emergency trolley and the other two were engaged in conversation. The previous Sunday staff had discovered that a number of items were missing and a drug Lignocaine was out of date. Rewriting the list was to ensure they could catalogue drugs and equipment in stock. The CNMI told me she had contacted the pharmacy and asked to have the expired drug replaced but was told there would be a 3-4 week wait and in the interim to retain the drug on the trolley. Staff debated the issue particularly whether they could administer the drug in an emergency. They asked my advice. I responded that I would not recommend giving expired drugs and asked what they felt may happen if an expired drug was administered. The problem with the expired emergency drugs surprised me. I was surprised that the Pharmacist would allow an expired drug to remain in the Unit and not replace it immediately. I wondered how long it was since anyone had checked the emergency trolley. I was surprised that the Doctor was not asked about the drug or that the internet was not utilised and surprised that he did not interject with knowledge as he may be called upon to administer the emergency drug’ (FNII).

Individuals are intimidated by group power, their mental activity is not free and there is a lowering in each individual of his own sense of responsibility for the work (Freud, 1921a). When intellectual ability is lowered the most contradictory ideas exist in tandem and tolerance without conflict about the logical contradiction between them. The hospital is a pre-existing structure independent of its members (Menzies Lyth, 1988, Menzies Lyth, 1989, Main, 1957) making it difficult to identify responsibility. The system is greater than its individual parts, greater than the group who sustain it. It has the qualities of the big Other protected by a fragile unsustainable Master discourse which individuals could challenge. To managing the fragility identified gaps are projected outwards by criticising external systems;

‘Something’s could be better, especially the community service. Sometimes I find that some patients are better managed in the community’ (PN4).

Alternatively external institutions such as the Mental Health Commission lend authority to group functioning via the discourse of the law, a stability keeping occupants in check, internally they keep themselves in check by operating simultaneously as basic assumption groups (Bion, 1990) and by retaining a shared ego ideal.

7.4.5 Dependency

The refusal to make decisions without reference to the consultant, the sustenance of the leader exemplifies dependency. Members behave inadequately or immaturely, knowing nothing and having nothing to contribute. In the earlier description of a patient requesting discharge, a group of senior experienced staff conducted a discussion. However the decision was retained for the consultant, who was unlikely to be any better informed about the patient’s condition, yet was expected to magically solve the difficulty. Dependency and the failure of the system to sustain the work of the members are described at different levels;

‘As much as the mental health act is there it is very hard because it is not clear. You are just left there in the middle and you just don’t know what to do. I know that they tried to make it as clear as they could, but when you are in a situation looking for an answer and there is none you are just left because you just don’t have the answer and you don’t know what the right or the wrong thing to do is. You see this is the problem if that was to be changed it would be easier. We do discuss with the team the best way to deal with an incident. But at 6pm on a Friday there is no Doctors and the patient wants – you are going through the folder and there is nothing there. You don’t want to implicate yourself legally and you don’t want to implicate the patient and you are just there and you don’t know the best way to manage the incident’ (PN4).

This decision making dilemma displays dependency, the *Mental Health Act* (Government of Ireland, 2001a) substitutes for the absent doctor; both are lacking in presence or clarity, evoking anxiety and challenging the attempt to be a good enough nurse. There is anxiety that the patient’s request cannot be answered and any decision may evoke punishment, managed by projection, criticism of the Other’s failure.

7.4.6 Working Group

Working groups, based on co-operation, require effort by individuals to understand others implying development in managing subject-Other relations. There was evidence of group members cooperating to achieve a common task; however the common task was maintaining the status quo and resisting change, suggesting that the strength of the unconscious desire for stagnation outweighed any conscious effort to develop, staff unconsciously resisted change;

‘There has been a trend towards change but a very slow and painful kind of change that hasn’t been achieved in any kind of satisfactory way. A change in philosophy and in ethos that has been for example scripted in things like a Vision for Change, or going back further to the document in the 1980’s a similar kind of ethos but the structures themselves and the kind of philosophy and ethos that dominates is very much a kind of medicalised philosophy and because of that people who come into the system are treated in a way that is consistent with that philosophy primarily’ (PN5).

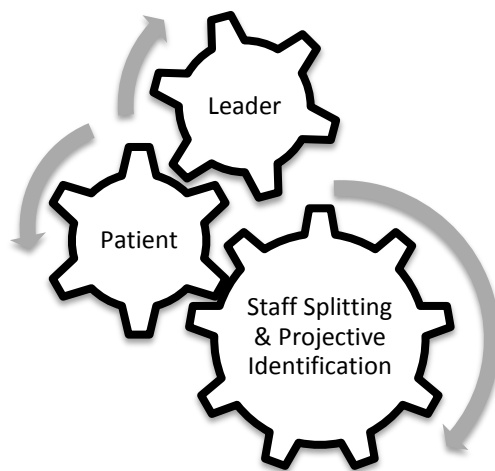
The staff group operates as a basic assumption group behaving as if members have united for paring, dependency or for fight/flight uses its energy to defend itself from internal fears and anxieties and does not develop or achieve effective output, emotions suffice the working group, ‘a sense of paranoia permeates the unit’ (Gilesnan, 2005b), causing conflict and leading to the development of specialised working groups.

Participants (PN1, PN6 & PN7) resist change attributing responsibility for engagement to external agencies; *‘I don’t believe in it anyway’* (PN1) and later attributing it with a power of its own; *‘it’s not up to the hospital to engage in conversation with the patients’* (PN1), *‘when the medication kicks in we will refer them on’* (PN7), to protect against the risk of action. By disavowing achievement, action is translated into basic assumption mentality. Thus saves the group from working rationally and co-operatively and from mediating between reality and the group. Like the ego the work group can be influenced and overwhelmed by emotions arising from unconscious processes.

Basic assumptions include the existence of a leader and display the same emotions, fear, hate, suspicion and anxiety, all observable in the data, these emotions are both revealed and suppressed as group rules provide containment for what is permissible.

Bion (Bion, 1990) concurs with Menzies Lyth (Menzies Lyth, 1989) placing projective identification and adult regression to infantile mechanisms as central to understanding group operations as protection against anxiety. The group in the unconscious is like the body of the (m)Other. Bion (Bion, 1990) argues that splitting and projective identification are used in relation to the group leader whereas Menzies Lyth (Menzies Lyth, 1989) believes they are used in relation to the patient, the data shows movement in both directions.

Diagram 8 Unconscious mechanisms in staff - patient interaction



Bion (Bion, 1990) and Freud (Freud, 1921a) are optimistic and believe development, change and improvement are possible if the group in facing reality realises it is facing itself, anxiety becomes manageable. Optimism was not shared by all participants, change occurs slowly and despite staff efforts is hampered by being part of the existing system;

‘Wouldn’t it be interesting to start again, and if we did start again would we build it the way it exists now and the answer is absolutely no. It would look nothing like what you would never build a psychiatric hospital like the ones you have now you probably wouldn’t build a day hospital to serve the kind of function you wouldn’t start from a medical bases and work up you would start from a much more pluralistic kind of equalised kind of thing where you would have different perspectives cohering in some useful fashion and you would have it very person-centred as opposed to diagnosis/problem centred’ (PN5).

Imposed change in the form of '*shared care plan*' (FN10), attempting a pluralistic approach is imposed by a big Other not generated by team endeavour. Data indicated that practices indicative of standard decision making regardless of individual assessment persist. The idea that all patients should be individually assessed is superseded by the removal of all new admissions clothes;

'They take your clothes off you in case you run out of the hospital, you know. That is so if you do manage to get out of the hospital you would be seen in your pyjamas and people would know that you are from the hospital' (PN9).

Patients become marked men and women. No individual intellectual capacity is employed in assessing whether this intervention is required.

7.5 Conclusion

The contemporary examples of transference presented are supported by research collated since Freud's earliest descriptions of the phenomena. This indicates the strength of the unconscious in utilising resistance and repression to mask its presence while providing evidence of an unconscious imperative to maintain a system that fails its inhabitants. The intrinsic unrecognised, unquestioned functioning of transference in services management of subject-Other relationships identifiable in critical incidents, examples of acting-out and mundane practices displays all attributed to patients or powerful Others, were observed as frequently contributed to by the (non)action of staff. The articulation of subjectivity, affects and the subject-Other relationship are analysable in reference to the mediation of transference evident in parapraxes and lapsus routes to the unconscious unacknowledged in favour of master, university and hysterical discourses. The data evidences that transference, omnipresent in subject-Other relationships, emerges in its natural form and is superimposed on therapeutic alliance and subsequently misattributed due to the lack of analytic discourse, consequently transference is unmanaged by staff and has a powerful negative effect. Refusal to recognise projections from the past exhibits resistance and repression; disavowal of service failures resulting in the inhibition of opportunities for productive therapeutic work and promotes the status quo which is of scant benefit to patients preventing progresses towards a practice focused on the provision of a social system which would enable the emergence of truth and/or recovery. The four formulations, transference, language, groups and leaders have been utilised to create a construction and exploration of transference in the research setting. The next chapter provides a discussion of what has been discovered.

Chapter 8 Discussion

This chapter reviews the study from the initial idea through theory, research methodology methods, findings, analysis and conclusions. Data generated was analysed under four psychoanalytic formulations; transference, language, groups and leaders and these formulations are used here to structure a discussion on transference in the Irish public mental health services. A fifth heading, psychoanalytic research, is included to explore the merits of the approach. Meaning emerged from the impossibility, the limits of signification from a paradox where words fail and the actions of participants give an account. This study generated new knowledge relating to the Irish public mental health services, reflecting previous studies in similar organisations evidencing the homogenous nature of institutions and increasing the potential application of recommendations in analogous settings. The analysis has uncovered gaps in understanding and potential areas for change. Admission to services to address the overwhelming anxiety provoked by mental ill-health, marked by the exposure and re-enactment of primary relationships, provides an ideal opportunity for staff to explore with patients the quality and structure of their objects of desire and to establish a treatment that avails of the psychical energy associated with the libidinal drive. Adherence to a reductionist approach to understanding symptoms results in misinterpretation of transference promoting a parental approach and maintains an engagement based on unconscious unhelpful conceptualisation of the patient as a minor.

8.1 Discussion of findings on transference

This study found that transference, the enactment of the unconscious in the subject-Other relationship, in services generates jouissance for staff evidenced in the excitement experienced by staff in the workplace (section 7.4.3). Consequently there is resistance to any interference with the current power balance which is sustained by the group's shared ego ideal. Patients are unconsciously understood as dangerous, sick, uneducated, problematic minors and staff as kind, moral, helpful and threatening parents (sections 7.1, 7.1.1, 7.1.4 & 7.1.5). Staff appear to suffer from narcissistic neurosis fuelled by the indispensable quality of their work and are confined by their reliance on Master and University discourses (sections 7.1.6 & 7.1.7) They are skilled at engaging in social relationships, initiating treatment founded on a biological

structure, managing crisis and in some instances initiating therapeutic alliance which results in some relief of patients symptoms. When transference appeared in a positive form it was treated with suspicion and rarely used to the benefit of the patient. Staff appeared unprepared to work with transference, which, when it arose in a negative form, was managed by dismissal, recourse to intellect or parental style care fostering dependence.

8.1.2 Patients as intrusion

The findings from this study appear to indicate that transference emerges in every treatment and is a driving force avoided in contemporary Irish mental health services. Staff fail to recognise their use of the same regressive coping mechanisms as patients when faced with the overwhelming suffering of the patient's condition. This was exemplified in the response to the tension in the unit at the time of the *'tobacco pouch incident'* and notable again in the contagion of the student nurse with patient's symptoms (sections 7.1.4 & 7.3.2). Staff, literally do not know what to do when they encounter the symptom of mental health services. What they are required to do, being with patients is overwhelming therefore they constantly make themselves busy being with each other or attending to bureaucracy (section 7.1.2). Patients are an unhappy intrusion in services warranting admission *'because they are very unwell and their families are sick of them'* (section 7.1). The intensity of caring was found to be a negative experience marked by suspicion and danger supporting Lacan's link between transference and hate expressed as ambivalence; the patient is a subject that you have to keep an eye on (Lacan, 1994). The only un-troublesome patients are the institutionalised, predictable and unchallenging and more likely to support the passive aim of the libidinal drive, being loved as opposed to loving. This group of patients were encompassed in fantasy about the past and *'real psychiatry'* (sections 7.2.5, 7.4.1 & 7.4.3).

The findings indicate staff's position as reflected in an obsession with assessment observation and categorisation and obvious failure to have meaningful discussion or engagement around intervention treatment and recovery, patients identified this as staff spending more time engaging with information technology than patients and staff identifying the lack of therapeutic encounters (section 7.4.1). This obsession with

assessment and observation requires the endless completion of paperwork which acts as a barrier a defence against encounters with patients. A total shift in approach to learning about and trying interventions with patients and engagement in supervision is required to unfreeze the current impasse. This would require giving up the current dominant discourse, relinquishing the ‘plus de jouir’ to enable transference management. ‘Plus de jouir’ or surplus jouissance refers to the cause of human desire (Skelton, 2006)p446. This is about the little something in the body of the loved one that makes them special and provides enjoyment. In the case of the mental health services I argue that the little something is the patient’s symptom. Patients are loved for their symptoms not for themselves. Staff observe and catalogue the symptoms to justify the system.

Both the literature reviewed and the participants indicated that admission to mental health care is an ideal opportunity to explore the quality and structure of patients objects of desire and to establish a treatment process that utilises the psychical energy associated with the libidinal drive. Adherence to the psychiatric reductionist model misinterprets the transference and promotes a parental approach preventing subject - to - subject engagement. The non-recognition by staff of their complicit participation in re-enacting early formative relationship creates and maintains a system that inhibits progress. Staff are polarised in their own and patients’ unconscious as good or bad objects. The patient as object rather than subject is part-owned by staff, undifferentiated, in the manner of the infant and prevented from engaging in the decision making process. Subsequently patients perceive staff as persecuting and fear annihilation and comply to protect themselves from being destroyed. There is a limitation to the ‘*wonderful quality*’ (section 7.2.4) of staff that patients must accept, they limit the quantity of libidinal energy they invest in the patient and the patient has to be content with the limitation. A demand for more is unacceptable and may result in the harshest of punishments the withdrawal of love.

8.1.3 Critical incident management

Finding relating to critical incidents they arise from staffs’ lack of engagement with patients and failure to tolerate anxiety their own and the patients’ which evokes omnipotence and aggression (section 7.1.4). Critical incidents are managed by the

imposition of restrictions or pseudo-treatment often medication administration reflecting impatience, guilt, hatred, and despair evoked by certain patients which compromises care. Incidents of acting-out by service occupants are a consequence of the failure to work with transference (Harari, 2001, Main, 1957, Shur, 1994). Acting-out is the demand for love and the attempt to avoid anxiety and was observed in patients and staff's response to the system (sections 7.1.4 & 7.3.2). Staff activities, attending to bureaucratic tasks, are designed to keep the patients at bay and can only be tolerated for so long eventually there is no choice but to act-out, to demand a libidinal response to reduce anxiety. The findings indicated that staff interventions with critical incidents mirrors patient and their family's behaviours resulting in the rejection, dismissal and even banishment of the patient from the system (sections 7.1, 7.1.2 & 7.1.5). The management of critical incidents by evoking a Master discourse and the power of the leader evidenced unrecognised and unmediated transference (section 7.3.4). Confining retrospective analysis of critical incidents to a systematic bureaucratic reporting system ensures that critical incidents are not subjected to any exploration of transference, the forensic process, a University discourse utilised seeks material rather than psychical evidence consequently they have a repetitive nature.

Acting-out, transference without analysis needs typographical and topographical exploration; an exploration for the place where something became unconscious, enabling the lifting of repression (Freud, 1912). Instead what is promptly re-established is an earlier experience of the Other and the associated repression is represented in the transference. Symptoms are a route to the unconscious and carry meaning. The symptom may have undergone several displacements, but has at its root a formation that needs uncovering and understanding, the 'replacing of what is unconscious by what is conscious' (Freud, 1917b)p486. This enables the lifting of repressions, removal of the preconditions for the formation of symptoms and allows pathological unconscious formations to be transformed into normal formations; then it is possible to find solutions. This challenge to current responses displays the gap between psychoanalysis and psychiatry. Psychoanalysis does not initially seek to remove symptoms; the emphasis is on finding meaning whereas psychiatry's tool box aims to remove or contain them. Patients and staff who act-out are not encouraged to speak. The response to self-harm and critical incidents is a rush of activity to reduce or remove the object/subject associated with self-harm, the placement of the patient in

a place of safety, and a shutting down of the incident (section 7.1.4). The staff member is rarely removed, transference remains unanalysed, staff fail as subjects supposed to know, and the patient is unconsciously directed to additional incidents of acting-out which feeds staffs misplaced belief in their worth. The unspoken becomes an unavoidable observation again;

‘Acting out equals transference without analysis, transference equals acting out without analysis’ (Harari, 2001)p84.

The findings indicated staff’s failure forces patients into a position where the demand to act-out is more powerful than the symptoms they experience. Critical incidents are misunderstood as a demand for attention rather than a demand for a demand. Patients and staff who act-out are bypassing the Other, it is a virtual transference. The Other has symbolically failed the subject; being with and providing a framework for symbolic work is absent and the subject regresses to a primitive or pre-symbolic state, an act of virtual transference. Critical incidents are reducible if staff operated differently on two levels; firstly learning the skills to manage transference, however, knowledge alone is insufficient. Therefore secondly additional learning, to better accept their negative feeling to patients who act-out by developing awareness of the mechanism of transference is required. This does not imply that all staff should be psychoanalysts rather they reconsider the importance of the subject-Other relationship’s contribution to patients unconscious structures. Lacan argues that the model by which transference is used in analysis is not that different from how we manage it naturally and the model of analysis which gives transference a structural quality could be used to introduce the ‘universality of the application’ (Lacan, 1994)p125. This is particularly important for consideration in services from which two conclusions can be drawn; firstly, and most unlikely, all staff are suffering from a constitutional lack to utilise their natural qualities to manage transference. Or, secondly, and more likely, membership of the group unconsciously prohibits the use of this natural skill. This power of the group to inhibit therapeutic work was identified as ‘*a tendency to be influenced*’ by staff new to the system (section 7.3.3).

To demand is not the same as to ask for. If demand is not met the Other is bypassed by the subject, the Other is no longer the subject supposed to know and virtual transference is demonstrated in savage acting-out. Harari's (Harari, 2001) signifier 'savagery' evokes Klein's (Klein, 1952) object relations theory, Freud's (Freud, 1921a) identification of regression to primitive states, Menzies Lyth's (Menzies. I., 1970) commentary on defence mechanisms and the savage attacks that patients commit on themselves. This is frequently met with a countertransference response from staff leaving the overwhelmed patient Otherless in directing their libidinal energy. The subject supposed to know becomes the subject who does not know; a direct consequence of failure in responding appropriately or providing an analytic discourse. Main (Main, 1957) noted that when staff learnt how to better accept negative feeling to patients who acted-out, the need to rely on medication to manage critical incidents dropped dramatically. The demand in services has been shifted from a demand for demand to a demand to follow routine obey rules and accept treatments indicating the destructive negative nature of admission and creating a situation where intense transference occurs but in unworthy forms, or paraphrasing Freud, it amounts to nothing less than mental bondage with erotic colouring (Freud, 1912)p101. The patient accepts or rejects the rules to gain a libidinal response from staff (sections 7.1.4 & 7.4.1). For staff the issue is built around a conflict, a choice has to be made between the unconscious influence of the group which is built around the lowest common denominator and the rules set out by society for service delivery (Freud, 1921a)(section 7.3.3). Lacking analytic discourse unconscious aspects of critical incidents remain unexplored, the meaning of the symptom can only be speculated on and understood at the level of behaviour; if it was understood as a symptom the jouissance for patient and staff becomes discernible.

8.1.4 Skills for managing transference

There was scant evidence of positive transference found, positive attributions were confined to commentaries about compliant patients and parental staff (section 7.1.5) and counterbalanced by negative accounts. When positive transference occurs symptoms are given up or no longer given attention by the patient; to the extent that there is a declaration of being well (Freud, 1912)p162. Powerful reversals occur and go unseen by staff.

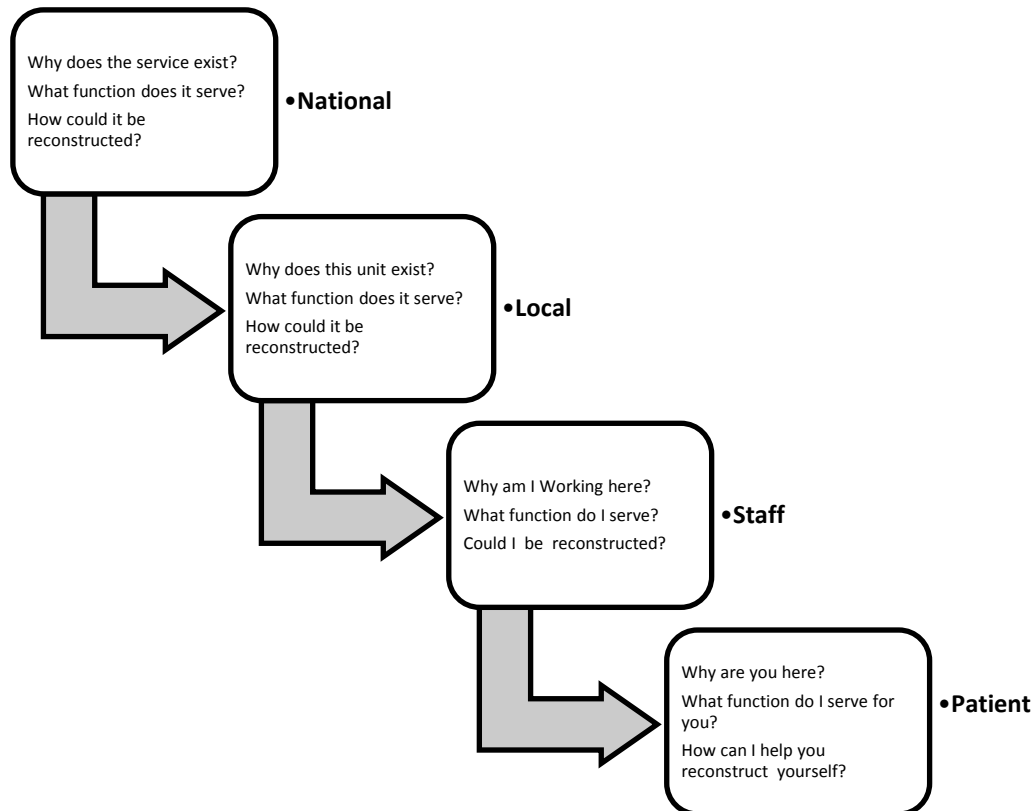
‘There is an interference with the continuation of the treatment which may be an expression of resistance’ (Freud, 1912)p162.

The analytic task of supplying the analysand with appropriate anticipatory ideas to challenge resistance, directing the analysand to look for the balloon in the sky (Freud, 1917b)p437, is required. Resistance is challenged by maintaining an analytic position; staff are not educated and informed in this practice.

If staff’s need for love has not been satisfied in reality they approach every new encounter with another with unconscious libidinal anticipatory ideas. Staff with unsatisfied libido will direct it at those expressing an interest in and appearing to show them love. This is expressed by staff and patients as an expression of satisfaction about the work (sections 7.1.2 & 7.1.5), the need for occasional respite from patients expressed as a desire for a special rest room (section 7.1), a desire to be rid of the patient (sections 7.1 & 7.1.5), a declaration of hate (section 7.1.2 & 7.1.5) or that a patient should remain in the system (section 7.1).

In the argument above I am apparently contradicting myself by advocating the use of ‘natural skills’ not rebuilding the service to deliver psychoanalysis to patients. The initial place for psychoanalysis in services is with the staff rather than patients, as psychoanalytic practice has the potential to free staff from the bondage of the social dynamic in which they operate. If staff were de-incarcerated, if the system was *‘a much more pluralistic kind of equalised kind of thing where you would have different perspectives cohering in some useful fashion’*, they would be positioned to demand a demand from the patient as opposed to using the patient as a source of jouissance (section 7.4.6) . Reflection on the nature and conduct of work is required. Reflection is a problematic word indicative of looking at an image of the self, a reversed fixed image that is captivating and narcissistic. Beyond reflection analysis is required, a deconstruction of the imaginary and analysis of its component parts. Analysis by staff of the service is required in relation to their needs and societies demands. Broad societal questions can be superimposed to analyse the specific situation, more specifically from local to the individual. If we demand something of ourselves we can demand something of the subject who is the patient.

Diagram 9 Stepped approach to engagement



Contained in the myth of Narcissus is the salutary warning, that love, if it is to be productive, needs to be aimed at an-Other as opposed to an image of the self. Being narcissistic involves placing an inflated value on one's own position to the extent that the other goes unnoticed and has no option but to fade away only appearing like a distant echo, a faint reminder that there is someone else needing attention, the patient's voice is but an echo. Findings included narcissism as a feature of staffs' beliefs about the value and the extent of their input with patients (section 7.1.6). Psychoanalysis commences with a sharing of knowledge, when transference emerges it has a libidinal quality that needs direction to another, the relationship to the Other is critical and is acted-out in transference. The service symptom, investing libido in the Big Other instead of the patients; who so objectified lose all the qualities of being another, is fuelled by the work of the occupants. Without an adequate response from the Other resistance appears powered by the unconscious libidinal drive. Intellect

alone will not sustain the work as guidance is only taken from someone we can love and trust. The Big Other's investment in or love for the institution is essential conversely requiring a decrease in the level of narcissism in the Big Other so as not to inhibit work. When senior staff suffer from narcissistic neurosis they have little or no capacity for transference, to love the institution. Staff's narcissistic neurosis is invigorated by a belief in the indispensable quality of the work (sections 7.1.6 & 7.1.7). They readily engage in intellectualisation, allowing some relief of the patient's and the institution's symptoms but reject demands for love, intellectualisation leads to discussions on power bases and minute resource management, economising on the use of paper and reducing personhood to the signifiers '*name, medications, key worker details, Register*', greatly distancing the patients (section 7.3.2). Staff externalise this failure of engagement by bemoaning the poor state of the services due to lack of financial support and bolster their inflated importance in displays of narcissistic rivalry between service providers indicative of a belief that their approach to patient care could not be matched either in another service or in another part of the service (section 7.1.7).

8.1.5 Failure to engage with patients

The finding concurs with the literature that transference is omnipresent unacknowledged and unmanaged in subject-Other relationships leading to a powerful negative effect on therapeutic alliances in the services (Freud, 1912, Lacan, 1960-1961) (section 7.1.4). Refusal to recognise what is being projected from the past exhibits resistance and repression and a disavowal of failures of the current situation that staff and patients operate in. This inhibits opportunities for productive therapeutic work and promotes the status quo which is of scant benefit to the patients and prevents any progress towards a practice focused on the provision of an enabling environment for the emergence of truth and recovery. The system fails its inhabitants primarily through the non-action and non-engagement of staff exhibited in their neglect to spend time with patients (section 7.3.2). Distorted use of transference allows subjects to repeat and fail to work through the structure created by primary relationships. Staff fail to recognise the unconscious equating to the primary object of the (m)Other and the later imposition of the name of the father. The inability to respond appropriately to patients' transference is a reflection of narcissistic elements

and intellectualisation that substitutes for therapeutic alliance. As there is no controlled interpretation of transference there is a subsequent lack of transference management and interpretation, consequently the services are a place of negative transference in which everyone is troubled.

8.1.6 Social expression with erotic roots

Interview data indicates that unconsciously participants held two conflicting sets of feelings in relation to others that populated the services; they were loved or hated. Feelings of friendship, care, sympathy and affection were counterbalanced by feelings of hate, disgust and hostility (section 7.1.5).

‘All the emotional relations of sympathy, friendship and trust and the like which can be turned to good account in our lives, are genetically linked with sexuality and have developed from purely sexual desires through a softening of their sexual aim, however pure and unsensual they may appear to our conscious self-perception. Originally we knew only sexual objects; and psychoanalysis shows us that people who in our real lives are merely admired or respected may still be sexual objects for our unconscious’ (Freud, 1912)p105.

The erotic quality of the libidinal drives are transformed into more socially acceptable expressions such as sympathy or fear, however the failure to recognise their libidinal roots strengthens resistance and leads to a homeostatic non-therapeutic environment or a regressive environment that strengthens unhealthy relational structures.

Data establishes the deception of love and enactment of the parental metaphor in service occupant relationships. Transference utilises distorted libidinal processes enabling subjects to repeatedly fail to work through structures created by primary relationships, which if addressed would enable development and differentiation. Working through is inhibited by staff’s failure to recognise the unconscious equating of nurses to the primary object (m)Other and doctors as big Other resulting in unresolved oedipal style conflicts. Unconscious male and female positions provide fertile ground for transference traceable to these re-enactments. Patients are allocated disposable qualities when staff engage in rivalry for the attention of the leader, founded on an ego ideal unbeneficial to service inhabitants (section 7.2.3). The

inability to move beyond narcissism and the intellectualisation of subject-Other relationships substitutes for therapeutic alliance.

Findings uncovered that most staff fail to acknowledge the unconscious and consequently defend a social system in which jouissance is unexplored, unmediated, unnamed, unaddressed and enjoyed. Naming and renaming services and symptoms occupied a significant part of the work aiding the University Discourse preventing analytic intervention. This provides a part explanation for the poverty of language and the passive-aggressive position of some professional groups who rather than engagement in the University discourse avoid coherent articulation of their position which would bring them into a real encounter with the strength of the transferences they deny (section 7.2.4).

8.2 Discussion of findings on language

Lacan's discourse theory describes four social bonds language based constructions of transference that determine the social functioning of the institution. In particular the data indicated utilisation of the University discourse to promote knowledge and defend against the truth. The generation of knowledge, is preferred over analytic discourse as a method of rationalising work. The knowing subject is the agent who excludes the unconscious. As discussed above (section 3.2.7) knowledge and truth are not the same thing, groups sacrificing truth to survive, they demand illusions and cannot operate without them. Sacrificing the truth for illusion supplied by general knowledge diverted the group focus from its stated task into maintaining illusion. The University discourse fails to come to terms with the real of the world instead striving to catalogue every aspect of it evidenced in the descriptive nature of DSMIV(American Psychiatric Association, 1994), a medical discourse dominating services, which in cataloguing every aspect of human behaviour categorises it as pathological. Data provided multiple examples of University discourse where staff asserted their social roles maintaining the established social order by claiming exclusive knowledge and authority, controlling exchanges and decisions. This assertion was supported by claims that other team members lacked knowledge of '*all the ins and outs of psychiatry and the medical model*', (section 7.2.1), rendering them incapable of decision making. Weight was added to this by a dismissal of psychological assessment ensuring reference to alternative formulations were kept at bay. Dominance of a unitary position was rarely challenged by staff who paradoxically maintained that a hierarchical system no longer existed; they lacked recognition of their contribution to its perpetuation which extended to the frequent exclusion of the patient, providing additional evidence of the failure to recognise the patient as a subject (section 7.2.1). It is likely the structuring effect of language is used by staff to promote the current system of recourse to a Master discourse. Language is used as a defence against the truth to create a catalogue of all possible presentations by subjects seeking care.

8.2.1 Missed opportunities to listen and speak

Discourse enables the attribution of meaning to inter and intrapersonal experience. The data is a jumble of words, the narratives of the participants and the observations of the researcher. Service reviews (Policy., 2005) indicate acknowledgment of the value of interpersonal communication and seek expansion of services to incorporate psychotherapy. However, scant attention by staff to the importance of listening and talking to patients was found (section 7.3.2). In the day hospital the word client was used to describe people attending for psychotherapy and patient to describe attendance for other activities indicating that patients availing of psychotherapy were subject to an unconscious dismissal by referring to them as clients and by the additional suggestion *'Psychology should come once they are well, for when they are finished their stint in the day hospital'*, (7.3.3). Patients spoke positively about staff but described them as too busy to engage in meaningful interactions (section 7.4.1). Staff spoke about systems, *sector teams, protected time, patient allocation, shared care plans and group activities* as methods of structuring work to ensure that patients were allocated both formal and informal opportunities to speak (section 7.4.2). Despite this and the claim by some groups that they spent much time with patients, patients were observed as spending extended periods alone. Staff interactions were limited to greetings in corridors, fractured conversations about business at office doorways, the gathering of information by stealth (section 7.4.1) and reactions to patient's demands arising out of critical incidents. Participants attributed workload as the main factor in preventing engaging with patients without any acknowledgement that the workload is the patients. Work volume for some professional groups reduced their interactions to brief encounters and for others ensured only the most superficial interaction with patients. Excessive paperwork, a strict routine, the prioritisation of non-clinical work, and the use of notices were exploited to hold patients at bay, defences protect the staff from exposure to the patient's and their own unconscious anxiety (section 7.4.1).

Data analysis indicates that by limiting engagement in linguistic encounters meaning is conveyed, responses evoked and negative transference disclosed. The meaning of a written notice or limited engagement in a corridor or doorway is alienating. This evokes a powerful negative transference a particular social bond that ensures a separation between patient and staff limiting opportunities for recovery. The recourse

for attention is acute displays of anxiety, the infringement of rules and acting-out all of which confirms staff beliefs that the patient is an unreliable minor.

8.2.2 Lack of professional language

Findings have shown that all staff participants except nurses had a specific shared language to describe their work and articulate their position. Nurses lacked any consistent professional language, used general terms to describe patient conditions often in vague non-specific ways reducing their impact with other professionals. This is analysed as either they do no work which was not evidenced in the findings or their work is structured around unmanaged unacknowledged transference love which is considered unscientific and unmentionable. This suggests that nursing work remains unarticulated. If nurses cannot articulate their interventions to patients and others they are less likely to be valued in the system. This lack is a direct enactment of the unconscious equating of the nurse with the primary object of transference, the (m)Other (Menzies Lyth, 1988). The literature attributes the mother/child dyad as a template for social bonds and the transference to staff by patients overwhelmed by anxiety. Mothers bond with pre-linguistic infants. The nurse's silence unconsciously re-enacts this pre-linguistic bond where the infant's connection with the mother is in the Real providing comfort in a threatening environment. Nurses use the defence of reversal into the opposite to its full effect in their relationships with patients. The patient's demand; a demand for love; the nurse's actions, performing duties, provision of fundamental needs, shelter, food and safety meets a percentage of the patient's demand but resolutely rejects the demand for love because love carries a threat a fear of annihilation of being totally subsumed by the work. In the culture of knowledge and best practice the nurse is unlikely to report love or hate for the patient. The primal relationship evoked between the two would be unacceptable in the formal health care setting; the signifier love is translated into care delivery which is acceptable. To defend against the libidinal link care delivery is minimised and retained as indescribable, hence the reluctance to articulate a position. To protect themselves nurses direct their desire towards an-Other, the doctor, who has the power to save them from the demand of the patient and the embodiment of power that nurses lack described in the disavowal of their authority as *we have no control at all* (section

7.3.4). Potential the experience on having no control relates to the nurse's unconscious desires rather than the control of the patient.

This is problematic as the patient is unable to articulate pre-linguistic affects strengthening the reliance on the nurse as (m)Other to put words on them. The nurse unconsciously takes the role of identifying with the desire of the patient and like the mother does this through interpretation. The mother is caring for an infant who is pre-linguistic; the nurse recreates the mother-infant dyad by not speaking to but speaking for the patient at MDT meetings and during reports, imposing their rather than the patient's meaning and desire into the care relationship. This results in strengthening the alienation experienced by patients. The silent nurse disavows the patient's desire.

8.2.3 Encounters with nurses are encounters with the Real

Findings imply new knowledge about the nurse patient relationship. The encounter with the nurse is an encounter with the real. The nurse has a quality outside of language that is experienced but not articulated, an encounter of overwhelming anxiety without the acknowledgement that 'unbearable suffering is experienced by the unconscious drives as, on the contrary, as satisfaction' (Leader, 1995)p141. The nurse is experienced as a (m)Other with whom desire can be satisfied but this is a false connection that needs to be worked through (Freud, 1915b, Menzies Lyth, 1988). The patient desires to be desired and transference taking its model from nonanalytic relationships is initially addressed towards knowledge, therefore, staff become the subject who should be desired and know (Lacan, 1960-1961). The patient is separated from the knowledge they expect to have about themselves and expect to find it in the speech of the Other. If the staff have no understanding of what is happening and do not speak or limit speech to dismissal, the patient experiences only alienation (section 7.4.1). Staff's neglect of transference is a neglect of their responsibility. The infant is unable to articulate pre-linguistic affects and the patient in regressed mode is similarly unable to articulate strengthening the normal reliance on the (m)Other to put words on affects. This is problematic suggesting that the nurse has to identify the desire of the patient, adding to the alienation that is experienced; '*Taking your clothes off you*' (section 7.4.6), is analysed as taking the infant role being dressed and undressed by the (m)Other, handing over identity in the form of

garments. It is both passive and active it is about the nurse doing something and the patient being a passive recipient of their actions. The stripping of identity criticised by Goffman (Goffman, 1961) serves a function allowing staff without analytic discourse to participate in the re-enactment of infantile drama.

8.2.4 Operating in the Imaginary

Where there is a lack of language and an excess of anxiety the subject operates in imaginary relationships with the image of the nurse experiencing *jouissance* by basking in the love or punishment they receive (sections 7.1 & 7.1.4). *Jouissance* is outside of language and requires regulation through social order, therefore it is not surprising that nurses play a significant part in managing the structure and day to day delivery of services (section 7.4.5). Excess *jouissance* is managed by diverting it through language. Nurses without language retain power over the patient to maintain the status quo of being subject supposed to know; a mother knows best scenario retaining the patient as a personal phallic object freeing the nurse from the desire to be the desire of the doctor. The findings indicate that despite the biological reality that not all nurses are female and all doctors are male, unconsciously they are cast in male and female positions (section 7.3.4). The infant is a phallic object that fulfils desire for the mother; the patient serves this same function providing a satisfaction for the nurse's desire. If nurses engaging in therapeutic work, used language to engage the patient, shifted from the imaginary to the symbolic order, they would risk losing the phallic patient being exposed and castrated by language, instead they spent time creating basic assumption groups, committees, which allow illusions of a therapeutic social bond to flourish (section 7.2.4).

In the traditional system the doctor takes the master role and there is an obvious oedipal triangular structure between doctor nurse and patient. Service reformation, the introduction of additional professional groups and grades of staff has added complications to the equation as each have a competing master discourse. This has increased competition for retention of the patient as a phallic object or submission to being the object of desire for the master.

The lack of language is a powerful way to maintain a position that is complicated by the nurses' role in management care for groups of patients. The nurse is (m)Other to many infants while other professionals have the advantage of seeing patients individually so that time and transference with patients is contained. Nursing's role includes managing social order, attempting to limit jouissance and minimising contagion and distress, an impossible act of caring.

An additional possibility pertaining to the lack of nursing language relates directly to transference.

'Things that have to do with love are incommensurable with everything else; they are, as if it were written on a special page on which no other writing is tolerated' (Freud, 1912)p160.

8.2.5 Not risking being incommensurable

If nurses articulated the desire in the relationship with patients they risk being incommensurable with everyone else; a significant risk. Mental health interventions concentrate on managing symptoms tending to ignore or dismiss love as a troublesome complication in the manner of Breuer (Freud, 1901-1905). Being risk adverse not acknowledging and working with libido contributes to stagnation. Analytic treatment cannot ignore desire it follows libido and makes it accessible to consciousness and serviceable to reality by commuting between the imaginary and the symbolic order.

Jouissance and its subsequent (mis)management has come to the fore, mismanagement is a misleading term suggestive of conscious action. Staff do everything in their conscious power to disavow the unconscious creating an environment in which jouissance is unexplored and unmediated, unnamed it remains unaddressed.

8.3 Discussion of findings on Groups

This study is a theory of a specific situation an articulation of the truth of a mental health service, a homogenous social situation structured by subject-Other relationships. This does give the finding idiographic generalizability, however the findings have cautious transferability to similar situations. This claim is supported by the evocative nature of previous psychoanalytic studies of groups (Freud, 1921a, Menzies Lyth, 1988, Main, 1957), and the value of psychoanalytic research, as it speaks to and addresses gaps where other research methods fail. The primary intent of applying psychoanalytic theories to organisations is to offer the opportunity to alter key relationships between and amongst occupants, (Diamond, 1993). Change is brought about by insight, awareness and action in subject-Other relationships. The findings have addressed insight and awareness; recommendations for action are made below (section 8).

Much attention in the finding has been given to the influence of the group on the individual and its consequential negative effect on transference (sections 7.3 & 7.4). Societal change, the decline of the traditional family or more precisely acknowledgement that the social fantasy that such a family really existed in a harmonious manner, demonstrates how groups operate. Groups are the fundamental building block of society through which language developed; they are bound together by love expressed through language and action. Improvement in services will only be achieved if a working group structure can be fostered. The shared ideal that binds the mental health services group together requires re-evaluation, this has an implication for *The Vision for Change* Policy (Expert Group on Mental Health Policy, 2006). The ideal of the past, colleens dancing at the crossroads was supported by the banishment of Sean-nós dancers to the asylum and other institutions and replaced by the ideal of a River Dance where ever bigger groups dance to the same loud brash hypnotic unsustainable beat. Group members felt most sustained when their individuality was acknowledged and most alienated when it was dismissed, a postmodern style of group that can engage with a Sean-nós approach to mental health needs to be fostered, the organisation of treatment structures around a system of categorisation the DSMIV (American Psychiatric Association, 1994) makes that unlikely. Psychoanalysis

readily acknowledges not having all the answers to mental suffering. The evidence from psychoanalysis demonstrates that as well as working with patients as subjects it is possible to work with those who work in the clinic of mental health transforming their ability to become part of a postmodern approach. Madness is alienating and psychoanalysis could play a significant part in reducing alienation by supporting staff in transference management. An Irish psychoanalytic contribution to public debates on mental health is required to enable distinction between social fantasy and social reality.

8.3.1 Its all an illusion

Groups demand illusions and cannot operate without them, giving ‘the unreal precedence over the real’ (Freud, 1921a)p80. The group protects itself from the truth by recourse to myths, the group’s symptom embodied in narcissistic beliefs about the value of services (section 7.1.7). The group’s primary objective is survival its energy is diverted from delivering care; it is immersed in maintaining illusion such as *we don’t do addiction in psychiatry or that a hierarchy does not exist* (sections 7.2.5 & 7.4.4). Truth is sacrificed along with understanding madness as modern science renders madness meaningless by ignoring the concept of truth (Lacan, 1993a). The exclusion of the patient from the MDT meeting allows staff to avoid the truth retaining the patient as one whose version of truth even when articulated is untrustworthy (section 7.2.1). The truth is that when the patient is allowed to speak they identify the lack of analytic discourse in services (Policy., 2005). The concept that the patients’ attendance at the MDT meeting is *more stressful for the patient’s than the illness itself* has some truth however the stress may belong to the staff rather than the patient.

8.3.2 The illusion of a science of madness

Services are constructed on an illusion, a science of madness and normality; defended by recourse to the law and the Big Other. This constitutes a real struggle that exists for psychiatry, to protect itself it created the DSMIV (American Psychiatric Association, 1994) providing an evidence base beyond questioning. Previous studies have addressed the fallacy of the psychiatric assessment structure such as Rosenhan (Rosenhan, 1973) study ‘*On Being Sane in Insane Places*’ in which participants

feigned symptoms to gain access to hospital and reverted to normal behaviour following admission. The normal behaviour of the pseudo-patients was deemed to indicate insanity by staff operating on the belief that they were insane. A pseudo-patient study by Winkler (Winkler, 1974) yielded similar results and reported on negative transference between staff and the pseudo-patients; with the pseudo-patients reporting a sense of boredom and monotony which was 'capable of producing behaviour normally labelled 'ill'. Similar to Rosenhan (Rosenhan, 1973) study findings indicated that 'normal' manners were suspended on wards indicative of a particular type of social bond.

'Those who asked uncomplicated questions about their treatment were answered as though they were infants; if they became upset they were disregarded and disparaged by the inference that the complaint indicated irrationality. Patients were obliged to wear pyjamas following admission, or as punishment for various misdemeanours to make them realise they were sick' (Rosenhan, 1973).

Almost four decades later this style of regime continues to flourish, patients in this study were required to wear pyjamas following admission (section 7.4.6) and were disregarded, treated as minors and considered irrational; Oury's (Reggio, 2007) comment that the hospital is ill remains true. The social bond between staff and patients is characterised by unconscious preconceptions resulting in negative transference.

8.3.3 Intervention about the Other

The analysis is not merely an antipsychiatry argument as care reflects society's belief that medicine embodies the subject supposed to know. Psychiatry's domination a University discourse, that the truth of mental illness is biologically based, is challengeable by a postmodern approach where a single truth is unacceptable. Psychiatry dominates - antipsychiatry has failed, however post-psychiatry and psychoanalysis are contributing to shifts in conceptualisation. Post-psychiatry and psychoanalysis need to make an intervention at the level of philosophy about the Other and ways of working with others. The asylum, as a social solution is a residue of a past founded on a conspiracy of silence and repression whose longevity is ensured by the unconscious transmission of its power to detain repress and silence

occupants within a narrow mental and moral framework for society. It operates as a big Other characterised by punishing sadistic methods that trap current occupants into unconsciously incarceration by a moralistic judgemental style of conceptualisation. Its punishing superego is cloaked in pseudo-scientific language by the subject supposed to know supported by the discourse of the Master and law (section 7.4.1). Incarcerated staff attempt self-redemption by dismissing the patient as subject, recourse to chemical solutions, physical restraint or unrealistic rehabilitation and recovery plans. The challenge for psychoanalysis is to address the structure and function of mental health services without being dismissed as unscientific.

8.3.4 Failed reformation of the subject-Other relationship

This thesis commenced with an acknowledgement of the reformation of the mental health services. Despite statutory revision (Government of Ireland, 2001a) there is no evidence of a reformation of the management of the subject-Other relationship instead the reformation of services has enhanced and entrenched the previous regime. Negative transference was as firmly established in the community as the inpatient setting indicating that the shift to smaller inpatient populations and an extended community service has failed to address the critical subject-Other relationship; this was demonstrated by the hoped for wish that the patient would emigrate; captured in the phrase *his true colours are coming out*, which when reversed says more about the speaker than the spoken for (section 7.1.5). Freud (Freud, 1912) noted the negative transference that exists in the institution, this negative transference still exists. Foucault (Foucault, 2006) identifies no possibility of a change in the foreseeable future due to the elevated status of the doctor, a shift in the social order is required as noted in the findings that the position of the psychiatrists is a dominant thing in society given status beyond its utility in mental health supported by the bizarre transposition of the value of other branches of medicine (7.3.2).

The unconscious transition from individual to group psychology' as a powerful influence over individuals is evidenced. The desire to belong influences subject-Other relationships and elevates group cohesion over therapeutic work. This displays the requirement for systemic change to enable the development of a dynamic mental health system. Legislative and policy changes (Government of Ireland, 2001a, Expert

Group on Mental Health Policy, 2006) have resulted in no identifiable decrease in the rates of psychopathology. Conceptualisation of an appropriate approach to delivering mental health care is required. The change agenda needs to shift from management and regulation of services to an emphasis on the conceptualizing of mental structures, educative and process considerations.

8.3.5 Student nurses and contagion

Sinister and disturbing elements of contagion were found. In the example of the student nurses both students followed patient patterns of wandering and pacing aimlessly (section 7.3.2). The male student appeared more distressed than his female colleague taking his lead from the distressed patient in need of staff attention. The student, lost on his first placement, unable to articulate his distress, identifying with the distressed patient, overwhelmed by anxiety, sends the same appeal to staff. In need of someone to identify with he made an unconscious choice by identifying with the person with whom he shares overwhelming anxiety. There seems to be no opportunity to engage with or form a bond or positive identification with qualified staff and the finding evidence students as having a nuisance quality unless a unit was short staffed (section 7.3.2). The element of learning how to be with patients is absent for the student however other findings included the pressure to conform to group identification is inevitable. To integrate themselves into the staff group students have to reject the patient following negotiation of transition from individual to group psychology in the institution (section 7.3.3). Students are part of the system, but are not fully integrated having to contend with a split between academic and clinical experience, negotiating being part of two groups, university and institution, contend with the imaginary and the real without a formation of the symbolic.

8.3.6 Male and Female positions

Unconscious equating between the positions of doctor (male) and nurse (female) was found. Freud (Freud, 1937-1939) noted differences between male and female positions in transference, arguing that masculine protest, (fear of castration), prevents the male from subjecting himself to a father-substitute leading to a stronger transference resistance and a refusal to accept that the analyst plays a part in recovery. Transference resistance was evident in conflict between male staff in relation to

patient care and treatment choices. The female's wish for a penis is unfulfilled in analysis and analysis will be useless if she has an internal conviction that nothing can be done for her. In maintaining female desire, in particular desire as nurse to come together with the doctor and produce a Messiah the nurse is unconsciously complicit in maintaining the traditional system even stating that other staff groups and patients, her rivals should be excluded, *Psychology should come once they are well, for when they are finished their stint in the day hospital*, (sections 7.2.3, 7.3.2 & 7.3.3).

Exemplifiers of oedipal conflict were indicative of resistance by males and females to participate in analytic discourse. Critical incidents relating to patient behaviour provided ideal opportunity for staff to reflect on subject-Other relationships and transference. Exploration the transference would provide opportunity for alternate approaches, beyond behavioural charts, boundary setting and dismissal, an approach that could facilitate an emotional corrective experience for staff and patients. Resistance prevents change, recognition of analytic discourse could unknot the approach; the psychical reality of the re-enactment of an oedipal conflict could be addressed. Analytic discourse may have given staff opportunity to work with and on their management of the dynamics of critical incidents.

8.4 Discussion of findings on Leaders

The high value placed on doctors by society invariably casts them in the role of ego ideal, father and big Other making them the subject of powerful transference. This direct effect of being a subject supposed to know is welcomed by some and rejected by others as *medical ascendancy* (sections 7.2.1, 7.3.2, 7.4.1 & 7.4.4). The literature indicates that the ego ideal can be based on, the father (Freud, 1905c), the mother (Klein, 1952) or the specular image (Lacan, 1993a) indicating it may differ for individuals and this in some way constitutes what we become, man, woman or narcissistic being unidentified at the level of the unconscious. This ideal ego based on the biological father is enacted in the role of a patriarchal figure the head of the organisation the one who must be obeyed. There is a constant deference to such a leader as ultimately he owns everything and everyone and can sanction actions. Menzies Lyth (Menzies Lyth, 1989) conceptualised the nurse patient relationship as a re-enactment of the mother infant bond placing an emphasis on the management of excess anxiety. The father is not excluded as he has a role in separating the mother/child dyad; he is the instigator of the law. Lacan shifts thinking about the development of the ideal ego demonstrating that we recognise the self through a specular image and emphasising language replaced the father with the name of the father, which is the law. The social bond is created via the symbolic order. There is a constant searching by the individual for sense making via language which reduces social engagement to internally and externally checking where we are positioned in relation to the Other. Interpersonal interaction is all about the self and where the self is implicated. If the social bond in a mental health service is structured on the conscious ego the transference is all about the position of the staff and the patient is reduced to the level of object whose only function is to generate *jouissance*, perpetuate the system.

The implication of this is not that one psychoanalytic theorist is right and the other is wrong but that for individuals one step in the formation of their fundamental structure may be more influential than another. This results in an unconscious intrapsychical pattern of how social bonds are formed and maintained. As the subject develops and moves into new social structures the full weight of the pattern comes to bear upon their individual psychical structure and accommodation/adaptation takes place; to be part of the group you have to adapt to the group's unconscious norm.

8.4.1 Unfruitful investment

The patient investing in the ego ideal of the unconcerned leader suffers unsatisfactory treatment provided by the subject supposed to know. This was exemplified in participants' dissatisfaction with the amount of time they got from staff and the side effects of medication (sections 7.1.2 & 7.4.1). The fiction of staff cooperation contributes to retention of a dependant group and castrated leader in an anxiety provoking system structured to generate and facilitate staff jouissance. Patients provide a 'plus de jouir'; their surplus quality retains them as objectified interchangeable and disposable. This physical excess of patients and psychical excess of symptoms managed by observation and categorisation enables staff to minimally engage; patients are seen and not heard. Excessive quantities of negative transference towards individuals are managed by projecting it onto service structures. This alleviates fear that the (m)Other will be destroyed with a consequential conceptualisation of a threatening social system with responsibilities, power and the negative attributes of a bad object. The hospital is named as not having responsibility to engage with patients and the responsibility for improvement handed to medication and external agencies (section 7.4.6). The hospital as bad object is oblivious to appeals for help, but provides physical containment and rejects the subject's appeals to be desired. Specialised working group exist to retain the status quo leaving the responsibility for change located in external agencies, protecting the group against the risk of action (section 7.4.6).

8.5 Discussion of findings on Psychoanalysis

Psychoanalysis does not aim towards a *weltanschauung*, a world view, it is 'one discourse amongst many, not the final ultimate discourse' (Fink, 1995a)p129, yet it is worthy of attention because it gives us an understand of the functioning of the discourses outlined by Lacan that represent the fundamental elements of social reality, in a unique way (Novie, 2008)and enables alternative approaches to conceptualising mental health. Without knowledge and experience of analytic discourse it is unlikely that transference will be managed in services in a consistent formative positive manner. Attempts to apply psychoanalytic theory to other objects cannot claim to be doing applied psychoanalysis, since psychoanalytic theory is not a general master discourse but the theory of a specific situation. The discourse of the Analyst is not claiming the position of metalanguage simply identifying the primacy of subjectivity.

Psychoanalysis is a treatment, a method of investigation and a body of knowledge founded on a belief in the unconscious. Challenges in relation to the unknown the unseen are not new, the greatest challenge being know thyself when we are subservient to an unconscious. Acknowledging the unconscious acknowledges our dependence not on intellect but on the subject-Other relationship structured through desire. If desire comes before everything else, it becomes the singular most significant element in our development, those who control love, control the subjects who desire it, this information is lost in services.

8.5.1 Patriarchal structures

Tuke and Pinel (Foucault, 2006) recognised the family structure as a place where desire developed but when they replicated this in the institution were limited to a patriarchal structure. Nightingale's lamp (Flint, 2010) represents an authentic love which has been dimmed by strict structure, replication and uniformity. The postmodern approach to mental health has reduced the strangle hold of a patriarchal system the only way to retain what is left is to develop a more scientific discourse. The evidence of this study hinges on services dominated by a patriarchal model of institutional care, an un-illuminating conclusion unless there is consideration of something hidden. One of Lacan's final pronouncements on the Unconscious was

that the Unconscious just is (Lacan, 2008) we all know what it is. Could there be anything less radical than saying that services are dominated by patriarchy, it's known, we cannot imagine service without it therefore it's beyond question. It is an unconscious trap of such strength that we stop amalgamating in discussion the elements that keep it in places; the medical model (Foucault, 2006), the imaginary content of health policy (Fotaki, 2010) group psychology (Freud, 1921a), the impossibility of caring (Menzies Lyth, 1988), the operation of transference in the subject-Other relationship (Lacan, 1960-1961), and an on-going incestuous relationship between staff which excludes patients.

Consistently high readmission rates (Daly, 2009) indicate either a failure of the biological model or the success of the patriarchal model. Staff, unconsciously enslave patients, the only new treatment that should be considered is treatment for staff, as previously advocated by (Main, 1957). Irish consultation documents, commissioned research and government policy over the past ten years acknowledge deficiency and dissatisfaction with current regime's (Government of Ireland, 2001b, Keogh, 2002, Crowe, 2004a, Policy., 2005, Expert Group on Mental Health Policy, 2006), yet services persist in delivering the same unsatisfactory treatments. Ignoring the evidence of consultation and research evidences unconscious collusion with the retention of a system designed to pleasure those in charge paradoxically evidencing negative transference.

8.5.2 Incestuous pleasure

Social institution puts blocks in place that serve as a resistance to change to protect staff from the anxiety of caring as identified by Menzies Lyth (Menzies Lyth, 1989). This analysis is correct to a point for some staff. This study shows that there is a second unconscious activity that blocks service reform, the fulfilment of jouissance for staff. The retention of the patient in the role of minor allows the Other to sate his/her incestuous pleasure at the cost of the subject's mental health. The patient as subject of unconscious sexual satisfaction is trapped in a pre-oedipal position by staff's unconscious conspiring to maintain readmission rates. Menzies Lyth (Menzies Lyth, 1989) identifies fragmentation as a defence against anxiety, underpinning her thesis with Klein's (Klein, 1998) theory of formation at a pre-linguistic stage. Lacan

(Lacan, 1977) conceptualises two experiences of birth, biological reality which is overwritten with birth into the symbolic order. Freud (Freud, 1921a) identifies the absolute requirement for language in the organisation of culture and society. Menzies Lyth's (Menzies Lyth, 1988, Menzies Lyth, 1989), research prefers pre-linguistic stages and fails to capture the structuring effect of language making her thesis somewhat incomplete from a Freudian/Lacanian perspective. Additionally Lacan's (Lacan, 1977) birth into the symbolic order includes the imposition of desire and the creation of lack resulting in an impossibility of wholeness. Social structures constantly attempt to complete something and are always disturbed by the lack which is managed by an appeal to the Big Other or the creation of impossible imaginary goals such a philosophy of holistic health care (Government of Ireland, 2006) suggesting that no change will occur.

The *Mental Health Act* (Government of Ireland, 2001a) is one such example setting out to protect patient's human rights and potentially inadvertently reducing them; a greater percentage of staff time is taken up by attending to bureaucracy reducing patient access to them. Similarly the shift to a community service is unsuccessful as the institutional structures have been replicated outside the walls of the institution; mental bondage does not require bricks and mortar (sections 7.1.4, 7.1.7 & 7.3.2). No consistent staff support or alternative education has been put in place.

8.5.3 Absent psychoanalysis

This study identifies that psychoanalysis plays a minimal role in service delivery. This may be due to the early rejection of psychoanalysis by Irish Psychiatry (Robins, 1986) and the Irish love affair with institutions. During the past three decades extensive social reform has occurred alongside the gradual decline of the residential institutional system; in the same timeframe interest and development of psychoanalytic training flourished in the Irish third level sector. However this flourishing of psychoanalysis is mainly in a private context and has not greatly influenced public services. An active engagement of psychoanalysis with the public mental health services could potentially positively influence patient care. According to (Busch, 2010) a number of authors have via research on the effectiveness of interventions have given the psychoanalytic community a roadmap toward the future

which instead of increasing marginalization, it seems that with enough innovative in interventions and public health-conscious research, relevant elements of psychoanalysis may be able to be incorporated into mental health services of the future.

Transference occurs in the subject-Other relationship even when there is no acknowledgement of the unconscious by participants. Freud and Lacan both identify that unacknowledged transference is problematic. The most effective way to bring about an acknowledgement of transference would be through staff education and development. Opportunities exist for the expansion of education programmes for staff and for the provision of practice informed by psychoanalytic theory. The argument is not for a total system such as the clinic of Le Borde (Reggio, 2007) but for subversion of what already exists. Main (Main, 1957) evidenced how a psychoanalytically informed system of support and supervision positively influenced patient care and staff satisfaction. Patients show clinical improvement when exposed to psychotherapy (Asay, 1999, Benner, 2001, Fonagy, 2000), participants in this study support that claim. Despite the evidence Crowe (Crowe, 2004b) identifies that lack of exposure of patients in the Irish system to psychotherapy. This lack is unlikely to change unless staff are enabled to give up current ways of working.

8.6 Scope and limitations of psychoanalytic research

Conducting psychoanalytic research has limitations; the limitations are due to the lack of a clearly articulated and agreed psychoanalytic research method resulting from psychoanalysts recognising that knowledge production is part of the university discourse which aims towards education rather than illumination (Parker, 2005b). However Freud regarded the psychoanalytic interview as a research method which is generally accepted as providing significant new knowledge about humankind; research and treatment occur simultaneously (Kvale, 2009). As outlined earlier science and research is expected to fit with a recognised scientific method. Freud (Freud, 1937a) and later psychoanalysts recognised this uneasy relationship and argued in favour of psychoanalysis being recognised in its own right as separate or differentiated from normal science. Doubtlessly psychoanalysis does not match the quantitative method and the only possibilities for recognition in this area of science currently appears to sit with neuroscience where recent studies show possibility of

locating activity in the brain that could be attributed to the unconscious (Peled, 2008). However psychoanalysis accepts the existence of the unconscious and already have a set of proofs in place for evidencing it so the finding of neuroscience while helpful are not a major concern for psychoanalysis and due to the reductionist approach of studies in this area do not fit with a psychoanalytic approach to the subject. With its current set of proofs the option is for psychoanalytic research to be aligned with a qualitative paradigm. From a normal science perspective this weakens the position of psychoanalysis or conversely it's possible to argue that this is the strength of psychoanalysis as it retains a primary concern with the subject. For Lacan psychoanalysis exists between mathematical science and ethics and he places considerable belief in the power of language and structure in opening up knowledge on unconscious processes. This in turn gives access to the subject's truth, 'a truth which modern science forecloses' (Glynos, 2002)p52, Science and psychoanalysis have different styles of relationship to truth, psychoanalysis is a discourse and discourse, like science, can have effects that are real.

8.6.1 Matching psychoanalytic research with other approaches

On the surface there are a range of matches between the work of the qualitative researcher and the psychoanalyst but some significant distinctions. Most notable even though psychoanalysis has been described for this study and by others as a clinical practice, a theory and a research method the emphasis in psychoanalytic writing has remained in the former two with psychoanalysis as research appearing as a less significant concern (Freud, 1937a, LaPlanche, 1988, Kvale, 2009, Parker, 2008b, Audi, 1999). The significant difference in psychoanalysis as research to other qualitative methods is that all psychoanalysts are researchers, although that is not the primary aim of their work. When an analyst makes research the primary aim they are reversing the usual approach to an analysis in that the analysand is not approaching the analyst for analysis instead the analyst approaches the person to address a question (Lievrouw, 2003a). This is problematic and the analyst has to pay particular attention to how they conduct the work. The research literature available demonstrates clearly that there has been much successful accepted psychoanalytic research work completed as single case histories or the analysis of organisations, (DeBoard, 2005). These successes can be built on to develop a body of knowledge about psychoanalytic

research out of which a method can be distilled, most likely in the form of applied psychoanalysis. However psychoanalysis has always questioned fixed methods, preferring instead a subjective approach where the analysand's free association dictates the pace and contributes to the process. It would be more correct then to say that psychoanalytic research is qualitative in nature and principle in having a flexible rather than fixed approach to data. This is not incompatible with qualitative research where the emphasis remains on principles of research rather than fixed rules. The result is a psychoanalytic research project that is required to adhere to the principles of the psychoanalytic interview and the discourse of the analyst. In addition the lack that exists in the symbolic order is described by Lacan as the locus of the signifier which demonstrates that 'there is no Other of the Other, that there is no such thing as a metalanguage', (Libbrecht, 2001b)p202. A definitive psychoanalytic research methodology would be an attempt at metalanguage and from a Freudian/Lacanian perspective would most likely fail;

'Any statement of authority has no other guarantee than its very enunciation, and it is pointless to seek it in another signifier which could not appear outside this locus (of the signifier) in any way' (Lacan, 1993a)p310.

Psychoanalytic research is located in the evocative narrative that fills a gap in understanding as opposed to an authoritarian proclamation on a total situation.

The most challenging aspect of psychoanalytic research perhaps is not for psychoanalysts but for the broader research community as a psychoanalytic methodology concentrates on the gaps the lapsus during the analysis phase. The result is a rich provocative subjective narrative that evokes something in the reader and fills gaps in understanding but that runs the risk of rejection by the broader research community. However, the general and at times unconscious acceptance by the community at large of matters unconscious is evidence in itself of the success of this form of research.

There is an additional problem with psychoanalytic research in that there is an internal debate in psychoanalytic communities about what constitutes research. Take for example Parker's (Parker, 2005b) criticism of Hollway and Jefferson's (Hollway, 2007) work. This debate is significant and helpful for anyone conducting

psychoanalytic research and mirrors other qualitative research concerns. For example the phenomenological method preferred by many qualitative researchers is the adaptation and manipulation of a philosophy into a research method. This manipulation of philosophy into research methods is useful as it helps us to get a deeper understanding of the world we occupy, but manipulation carries the risk of distortion something the researcher has to be mindful of.

8.6.2 Defending and expanding the approach

In this study the researcher took Lacan's (Lacan, 1988a) discourse theory and structures of the real symbolic and imaginary and superimposed them on Freud's (Freud, 1937a) clinical method augmenting it with psychoanalytic researchers approaches to legitimise the study. While the result is a defensible body of work the question must remain about its verifiability to external reality for it to be meaningful. This verification with external reality that is the laws and policies that govern service delivery and the observations of the researcher, while defended by the author can only be retrospectively measurable by taking the work to the additional level of publication with both a psychoanalytic and mainstream audience to evoke a response from the Irish mental health community. I could simply defend the work by suggesting that a rejection is evidence of resistance which is a support for the findings, but that would be unethical if it was the extent of the argument. Instead I need to consider applicability.

Previous researchers and psychoanalysts (Bion, 1990, Main, 1957, Diamond, 1993), have shown positive results from the application of psychoanalytic principles in health care settings. I have experience of successful psychoanalytic informed supervision of individuals and groups in the mental health services that have enabled change for staff. Additional work is required in an Irish context to trial a psychoanalytically informed supervision for mental health care staff to enable change in practice which could be subjected to outcome measurements such as;

- Frequency and quality of critical incidents
- Staff satisfaction and burnout
- Patient experience of staff engagement.

In addition the public health agenda requires the attention of psychoanalysts and there is real potential for further research and development in a number of key areas pertaining to the findings of this study and previous work (Busch, 2010);

- The development of psychoanalytic approaches to treat specific disorders and populations
- The development of psychoanalytic literature outlining for other professionals treatment protocols in psychoanalytic practice
- The development of training for non-psychoanalysts in understanding the unconscious
- The utilisation of research as a tool to state what constitutes an analysis.

Standard research projects conducted within the University sector normally recommend additional research. This is a total adherence and response to the University discourse a self-perpetuating project which searches for more minute detail that aims to uncover the essence of a question. True to the psychoanalytic approach and despite what I have outlined above about potential future directions of research, the recommendation is less for additional research and more for psychoanalytic engagement with the symptom of the mental health services the failure to manage transference in a positive manner. That engagement would incorporate the three elements of psychoanalysis, clinical work, research, and theory development. Any additional proposal for research would best be placed in the realm of all three via investigation of a clinical project, founded on the theory from psychoanalysis and the contributions of this study which was conducted as a research project.

‘A form of discourse analysis that aims to educate readers, rather than illuminate a text and open up questions about it would be represented in Lacanian terms as operating within ‘the discourse of the University’ (Parker, 2005a)p177.

8.7 Position of the researcher

I fully acknowledge my subjective approach to the work which emerges from a history of working in and for services clinically as a nurse and a psychoanalytic psychotherapist, as a service manager and in the University as a nurse and psychotherapy educator and researcher. This bias influenced how data was collected and analysed leading to a question about whether the study could have been conducted differently, doubtless it could however it would then be a different study and may not have yielded this set of findings. The findings are a measure of my actions which provide an illumination of a total situation. The methodology was influenced particularly by a Freudian/Lacanian approach to the unconscious again reflecting my background and raising another question about the application of a clinical method to the research process. The challenge of articulating a psychoanalytic research method and satisfying a University discourse was formidable. It required reliance on previous researchers work indicating the potential for the publication and dissemination of a psychoanalytic research methodology. However I conclude this this could be a risky and destructive process for psychoanalysis whose strength remains in the acknowledgement of the not all; not all material particularly some of what occurs in the unconscious can be fully articulated in language, the Real remains outside the grasp of the Symbolic. The absence of a prescribed process for psychoanalytic research creates latitude and has led to some authors attempting to articulate a method (Hollway, 2007) while others caution against this due to the risk of reductionism and consequential loss if adherence to the technique of psychoanalysis is not maintained (Parker, 2008b). The methodology employed was informed by a number of psychoanalytic researchers and additional qualitative researchers particularly from the field of ethnography and I deemed it fruitful. The combined method of interviews and observation generated sufficient data to make psychoanalytic formulations; retrospectively it could have been modified by conducting second interviews with participants and formal interviews in relation to critical incidents. Nevertheless, as this did not happen I can only speculate that additional or different data would have emerged and a modification of this nature would not have adhered to the instruction to free associate. Alternatively I could have concentrated on observing and interviewing patients, however it was apparent at all stages of the study that this group were disenfranchised and in order to understand the

social bond they were subjected to engagement with staff was essential. By collecting data from a sample of all occupants the study captured the total situation.

8.8 Conclusion

This study of transference management in an Irish public mental health service has confirmed knowledge that already existed on the powerful negative unconscious impact of admission for patient. The negative effect that exists is stagnating for all service occupants. Additionally new evidence emerged that the powerful effect of the group extends beyond residential services resulting in a replication of a powerful negative effect in the community which is supported by service structures, policy and statutory regulation. Findings have shown staff despite their belief in their worth as therapeutic agents engage with patients at the level of social relationships and rarely progress to therapeutic encounters. When therapeutic encounters are established the subsequent emergence of transference is mediated in a negative and destructive manner. Staff actions and speech exemplify the impossible act of caring.

The findings include new knowledge in relation to some professional groups, particularly nurses. The impossibility of caring results in regression and this lends itself to speaking for rather than with patients. This extends the work of Menzies Lyth (1988, 1989) to include consideration of the poverty of language utilisation by nurses with and about patient as a defence against the anxiety provoked by the encounter with patients. Within this speaking for rather than with a poverty of articulation is used to protect the nurse from acknowledging the strength of transference experienced in the subject-other (nurse-patient) relationship and the subject-Other (nurse-doctor) relationship. Nurses in failing to acknowledge the powerful position they occupy as (m)Other fail their patients. Doctors in insisting on retaining a patriarchal role enjoy the jouissance of other service occupants, thereby also failing the patients. Other professional groups seem to play a less influential role, however, this was not fully investigated.

Despite this dark conclusion staff and patients acknowledged that a process of change had commenced. For this process to have positive outcomes appropriate supports are required. A number of changes need to happen in tandem to enable sustainable changes to occur. Staff individually, and as a group may benefit from psychoanalytic

informed clinical supervision. Staff require a reformed education system where they are exposed to multiple perspectives on the aetiology of, and interventions for, mental health issues. There is a requirement for a shift away from the dominant biologically based medical system of categorisation and observation. This would require a recognition that the service is ill but that cure does not lie solely in medical discourse. A shift in the philosophy of services is required which would involve a radical reconstruction of the powerbase in mental health to a structure inclusive of the four styles of discourse. While the Master discourse remains constructed around one professional group as Leader it is difficult to conceive how constructive change can be instituted. A post-modern approach to services could result in an as yet un-conceived molten evolutionary structure built around a central premise that the elegance of the subject-Other relationship would be preserved and predictive of service delivery.

Much work needs to be conducted on the education of staff in the formation management and operation of groups. While I would preference the introduction of the unconscious and psychoanalytic theory to educational programmes, there is a genuine acknowledgement, borne out of the literature, clinical experience and this study that education alone will not enable change. Working from the ground up change will only occur through enabling staff to work differently, that is thinking differently, that is feeling differently, that is lifting repression and bringing unconscious material into consciousness a process that enables ownership of and responsibility for the work rather than the patients. Despite the call for change both at the ground and national level their needs to be acknowledgement that the past and current system of imposing change is unsuccessful and that no homogenous solution is possible, what is required instead is local projects designed to meet service needs, projects that subvert the system.

This conclusion has concentrated on the requirement for change in staff and is reflective of the finding that the patient does not exist. By this I mean that the individual's subjectivity is missed due to the application of general knowledge to understanding symptoms. Central to the work of the mental health services is the patient, without the patients there can be no services, this should be the service aim to have no patients. This aim can only be achieved if patients are enabled to speak and to speak in their own language. The most radical thing staff could do is listen and

listen carefully by setting aside the formality of assessment and categorisation by abandoning the structured formation of dancing in unison and adopting an appreciation for the individual subjective *Sean-nós* expressionism of the patient; recognition that madness is rendered meaningless by ignoring the concept of truth. The registers of the Real, Imaginary and Symbolic are knotted together by the symptom in which the identity, the truth, of the subject is located. Mental health service's approach characterised in the removal or repression of symptoms inhibits the speech of the subject. Mental health services weakness is that psychiatry, an unfinished project, masquerades as a subject supposed to know. Psychoanalysis is interminable as it recognises incompleteness and has much to offer in the treatment of the symptom of mental health services. This chapter included some recommendations in relation to the findings. These and a number of additional recommendations from the study are presented in the final chapter.

Chapter 9 Recommendations

This chapter consists of the recommendations arising from the analysis of the data and the discussion of the study. The study conclusions were presented under the psychoanalytic formulations; transference, language, groups and leaders and the additional heading psychoanalytic research. This study generated new knowledge relating to the management of transference in the Irish public mental health services. The subsequent recommendations have the potential for application in the Irish public mental health services and analogous settings due to the homogenous nature of institutions. Recommendations are grouped under the following headings;

- Recommendations for the clinic
- Education recommendations
- Policy recommendations
- Research recommendations
- Recommendations for psychoanalysis

The recommendations are based on the identified gaps in understanding and subject-Other relationship management. They are suggested as a structure to address the overwhelming anxiety experienced by staff and patients, provoked by mental ill-health and the constituting nature of the institution. They are designed to enable staff to capitalise on patient's contact with services which provide an ideal opportunity to explore with patients the quality and structure of their objects of desire and to establish a treatment that avails of the psychical energy associated with the libidinal drive. Additionally they can be understood as a starting point for staff to shift from a

reductionist approach to understanding symptoms which results in misinterpretation of transference and promotes an approach which maintains an engagement based on unconscious unhelpful conceptualisation of the patient as a minor. The identified weakness, that psychiatry is an unfinished project masquerading as a subject supposed to know should encourage all participants in the delivery of mental health services to engage in service revision and development. Psychoanalysis has much to offer in the treatment of the symptom of mental health services.

9.1 Recommendations for the clinic

This set of recommendations are the most extensive and have been subdivided into recommendations that relate directly to interventions with the patient, recommendations for the direction of staff's focus and attention and recommendations on clinical and managerial supervision.

9.1.1 Interventions with the patient

- The central focus of the work needs to shift from bureaucratic concerns to being with patients
- The obsession with assessment observation and categorisation needs to shift to meaningful discussion or engagement around intervention treatment and recovery to increase the opportunity for therapeutic encounters
- Patients need to be loved for themselves not their symptoms as admission should provide an opportunity to explore the quality and structure of patients objects of desire and to establish a treatment process that utilises the psychical energy associated with the libidinal drive
- The patient needs to be recognised as a subject as opposed to an object
- Patients should not be excluded from the MDT meeting
- Symptoms initially require exploration rather than interventions that aim to remove or contain them
- Staff need to challenge resistance by supplying the patient with appropriate anticipatory ideas
- The demand in services has to shifted to a demand for demand
- Patients should be enabled to speak in their own language, staff need to listen carefully and adopt an appreciation for the individual subject
- Staff interactions with patients need to be more structured and not reliant on greetings in corridors, fractured conversations about business at office

doorways, the gathering of information by stealth and reactions to patient's demands arising out of critical incidents

9.1.2 Staff focus

- The Hysterical Discourse needs to be incorporated into practice
- Staff need support in becoming skilled at initiating therapeutic alliance and managing transference
- Acting-out, transference without analysis needs typographical and topographical exploration; an exploration for the place where something became unconscious, enabling the lifting of repression
- Service personnel need to be less risk adverse about acknowledging and working with libido
- The staff member involved in a critical incident may need to be removed instead of the patient
- Staff need to be enabled to satisfy their need for love outside the staff patient relationship
- Senior staff need to take a lead in fostering altruistic attitudes
- Staff need to shift from intellectualisation about patient's and the institution's symptoms towards recognising the demand for love
- Systemic change is required to encourage action and engagement of staff with patients
- Staff focus needs to shift to an ownership of and responsibility for the work rather than the patients
- Excessive paperwork, a strict routine, the prioritisation of non-clinical work, and the use of notices to communicate with patients need to be reduced

9.1.3 Clinical and managerial supervision recommendations

- Staff require support for the intensity of the act of caring
- A total shift in approach to learning about and trying interventions with patients and engagement in supervision is required to unfreeze the current impasse in staff-patient relationships
- Retrospective analysis of critical incidents needs to switch from a systematic bureaucratic reporting system to an examination of the subject-Other relationship
- Exploration of transference would provide opportunity for emotional corrective experience for staff and patients
- Patients and staff who act-out need to be encouraged to speak
- Reflection on the nature and conduct of work is required
- Analysis by staff of the service is required in relation to their needs and societies demands
- Dominance of a unitary position needs to be challenged to enable recognition of the patient as a subject
- The poverty of language and the passive-aggressive position of some professional groups needs to be addressed
- Nurse need to recognise the part they play by not speaking to but speaking for the patient at MDT meetings and during reports, imposing their rather than the patient's meaning and desire into the care relationship

9.2 Education recommendations

This series of recommendation are suggested for formal and informal approaches to education. There is an opportunity for local in-service education programmes and for current providers of education in the third level sector for mental health professionals to consider these recommendations for incorporation in to current and future educational programmes.

- In order to better manage and reduce critical incidents staff need to operated differently by firstly learning the skills to manage transference
- Additional learning is required to better accept negative feeling experienced by staff towards patients who act-out
- Nurses require education to foster a consistent professional language to improve their impact with other professionals as unarticulated interventions contribute to their role being under-valued
- All grades of mental health professionals need a reformed education system where they are exposed to multiple perspectives on the aetiology of and interventions for mental health issues
- There is a requirement for a shift away from education focused around the dominant biologically based medical system of categorisation and observation
- All trainees in clinical practice require opportunity to engage with, form bonds and positive identification with qualified staff
- Learning how to be with patient's needs to be included as part of clinical practice skills training
- Much work needs to be conducted on the education of staff in the formation management and operation of groups.

9.3 Policy recommendations

Mental health care policy as outlined in chapter 1 has been subject to recent review and services are endeavouring to implement change. It is unlikely that a national review of policy will be conducted in the near future however that should not deter local services from considering how the recommendations of this study could be included in the delivery of mental health care, within the current framework as a genuine attempt to engage with the patient.

- The shared ideal that binds together the mental health services group requires re-evaluation
- A postmodern philosophy for services needs to be fostered
- Systemic change is required to enable the development of a dynamic mental health system
- The change agenda needs to shift from management and regulation of services to an emphasis on the conceptualizing of mental structures
- Consultation documents, commissioned research and Government policy that acknowledge deficiency and dissatisfaction with current regime's need to be enacted
- The service symptom, investing libido in the Big Other instead of the patient needs to be reversed
- A shift in the philosophy of services is required which would involve a radical reconstruction of the powerbase in mental health
- Service expansion to included ease of access to appropriate psychotherapy is required.

9.4 Research recommendation

Additional research is required to expand aspect of the study and to address particular questions that occur as a result of the work. In particular this study has identified some of the gaps that exist in relation to psychoanalytic research methodology that warrant attention.

- The psychoanalytic interview is a research method which is generally accepted as providing significant new knowledge about humankind, psychoanalysts need to promote the value of this method
- Psychoanalytic research needs to be verifiability to external reality for it to be meaningful. This verification with external reality needs to be addressed to a mainstream audience to evoke responses from the broader mental health community
- The public health agenda requires the attention of psychoanalysts and there is real potential for further research and development in a number of key areas pertaining to the findings of this study which include;
 - The development of psychoanalytic approaches to treat specific disorders and populations
 - The development of psychoanalytic literature outlining for other professionals treatment protocols in psychoanalytic practice
 - The development of training for non-psychoanalysts in understanding the unconscious
 - The utilisation of research as a tool to state what constitutes an analysis.

9.5 Recommendations on psychoanalysis

The final set of recommendations relate to psychoanalysis, theory, practice, research and integration with the mental health community.

- The model in analysis for managing transference which gives transference a structural quality could be used to introduce the universality of the application in the mental health services
- The initial place for psychoanalysis in services is with the staff rather than patients to free staff from the bondage of the social dynamic in which they operate
- An Irish psychoanalytic contribution to public debates on mental health is required to enable distinction between social fantasy and social reality
- Psychoanalysis need to make an intervention at the level of philosophy of services about the Other and ways of working with others
- An active engagement of psychoanalysis with the public mental health services is required to positively influence patient care
- Psychoanalysis needs to create opportunities to subvert current services and engage with the symptom of the failed management of transference
- Additional work is required in an Irish context to trial a psychoanalytically informed supervision for mental health care staff to enable change in practice which could be subjected to outcome measurements such as;
 - Frequency and quality of critical incidents
 - Staff satisfaction and burnout
 - Patient experience of staff engagement

9.6 Conclusion

In total 57 recommendations have been identified divided into sets for the clinic, education, policy, research and psychoanalysis. This is an extensive set of recommendation for change that cover diverse areas from local practices to national policy.

The central concern of this study was to address the management of transference in the subject-Other relationships of service occupants indicating that all of the recommendation should feed into that primary objective. A potential way forward would be to unilaterally introduce psychoanalysis as the primary model around which services are structured and designed. However that would result in the elevation of psychoanalysis to a Master Discourse for services which from a post-modern

perspective would be just as likely to fail as the current system. A more realistic approach is the introduction of options to service providers to consider how they manage subject-Other relationships. A model for this exists based on the work of Michael Balint (1896-1970) (Balint, 1957) which resulted in the formation of Balint groups.

Balint groups were first formed to help General Practitioners reach a better understanding of the emotional content of the doctor-patient relationship and so improve their therapeutic potential. This was later extended to include different health professionals. Balint groups provide opportunity to think about encounters which create dilemmas for professionals and through discussion about the relationship, the possibility of finding new ways forward with the patient.

The Balint method (Luban-Plozza, 1995) is founded on psychoanalytic ideas about the dynamics of human relationships and the group work is based on the clinical work of members. It utilises everyday language and participants do not require specialist knowledge. Groups are normally managed by a psychoanalyst leader.

New group members are encouraged to spend more time with their problem patients thus enabling them to concentrate on becoming good listeners. Subsequently the focus changes to studying the relationship between staff and patient in the context of every day ordinary-length encounters. Groups meet regularly so patient progress can be monitored. Groups are structured to encourage participants to volunteers to talk about a patient of concern. The group listens to the narrative without interrupting. When the presenter has finished, the leader invites the group to respond to what they have heard.

Responses may include questions, advice, emotional reactions induced by the patient's story and speculations about what else might be happening. The group leader discourages over interrogation of the presenter, as the aim is to get the group members to work on the case. Some variations exist on the process of Balint groups (Salinsky, 2002). The group is not a therapy group although its effects can be therapeutic. The leaders' aim is to keep the discussion focused on the staff-patient relationship and to consider how the patient is feeling and responding to the staff member.

Balint groups provide a safe environment for the discussion of interpersonal aspects of working with patients. They encourage staff to see their patients as human beings making them more interesting to listen to and easier to help. Members may gradually reach a deeper level of understanding of patients' and their own feelings. They provide an environment for the exploration of transference, which may be causing problems which staff can learn to avoid or even to turn to therapeutic advantage.

The Balint group as a solution is a final recommendation around the introduction of a psychoanalytically informed supervision for mental health care staff which has the potential to address many of the earlier recommendations in a bottom-up approach. It is clear that psychoanalysis is a marginal approach to mental health care in Ireland and that the current regime is firmly established while on the other hand there is a desire by patients and some service occupants to change. The potential for change could be harnessed via the introduction of Balint style groups into services.

References

- AMERICAN PSYCHIATRIC ASSOCIATION 1994. *Diagnostic and statistical manual of mental disorders : DSM-IV.*, Washington, DC American Psychiatric Association.
- AN BORD ALTRANIS 2007. Guidance to nurses and midwives regarding ethical conduct of nursing and midwifery research Ireland: An Bord Altranis.
- AN BORD ALTRANIS. 2012. Frequently Asked Questions about Prescriptive Authority Available: http://www.nursingboard.ie/en/prescriptive_authority.aspx?article=70728448-fb82-4c08-baf8-b243ff6803e4#faq1 [Accessed 24.06.12].
- APPI. 1999. Code of Ethics and Practice. Available: <http://www.appi.ie/code-of-ethics> [Accessed 24.06.12].
- ARON, L. 1996. *The Meeting of Minds*, Hillsdale NJ, Analytic Press.
- ASAY, T. P., & LAMBERT, M.J., 1999. The empirical case for the common factors in therapy. In: HUBBLE, M. A., DUNCAN, B.L., & MILLER, S.D., (ed.) *The Heart and Soul of Change: What Works in Therapy*. Washington, DC: American Psychological Association
- AUDI, R. 1999. *The Cambridge Dictionary of Philosophy*, Cambridge, Cambridge University Press.
- BALINT, M. 1957. *The Doctor, his Patient and the Illness*, New York, International Universities Press, Inc., .
- BANISTER, P., BURMAN, E., PARKER, I., TAYLOR, M., & TINDALL, C. 2006. *Qualitative Methods in Psychology A Research Guide*, Maidenhead England, Open University Press.
- BARRY, M., VAN LENTE, M., MOLCHO, E., MORGAN, K., MCGEE, H., CONROY, R.M., WATSON, D., SHELLEY, E., & PERRY, I. 2009. SLAN 2007: Survey of Lifestyles, Attitudes and Nutrition in Ireland, Mental Health and Social Well-being Report. In: DEPARTMENT OF HEALTH AND CHILDREN (ed.). Dublin: The Stationary Office.
- BEINS, B., C. 2004. *Research Methods A Tool For Life*, Boston, Pearson Education Ltd.
- BENNER, P. 2001. *From novice to expert : excellence and power in clinical nursing practice* New Jersey, Prentice Hall.
- BERGIN, A. E., & GARFIELD, S.L. 1994. *Handbook of psychotherapy and behaviour change.* , New York, John Wiley & Sons Inc.
- BERNARD, H., R. 1988. *Research Methods In Cultural Anthropology*, London, Sage
- BICKNELL, M., & LIEFOOGHE, A. 2005. Jouissance in an evermore stressful world. 22nd Annual Meetings of the International Society for the Psychoanalytic Study of Organizations Baltimore, Maryland USA IPSO
- BION, W., R. 1990. *Experiences in Groups and Other Papers*, London, Rathbourne Books
- BREUER, J., & FREUD, S. 1893a. On the Psychical Mechanism of Hysterical Phenomena: Preliminary Communication. *Studies on Hysteria*. London: Vintage Hogarth Press.
- BREUER, J., & FREUD, S., 1893b. Case Histories Fraulein Anna O. *Studies on Hysteria*. London: Vintage The Hogarth Press.
- BRITISH PSYCHOLOGICAL SOCIETY 2001 Code of Conduct, Ethical Principles, & Guidelines. Leicester: The British Psychological Society.

- BROWN, C., & LLOYD, K. 2001. Qualitative methods in psychiatric research. *Advances in Psychiatric Treatment*, 7, 350-356.
- BROWNE, V. 2003. *Psychotherapy in Ireland*, Dublin, The Columbia Press
- BRYSON, K., A. 2004. *Emile Meyerson (1859—1933)* [Online]. Internet Encyclopedia of Philosophy. Available: <http://www.iep.utm.edu/meyerson/#H3> [Accessed 11.05.12 2012].
- BURKARD, S. 1999. Psychotic Organisation as a Metaphoric Frame for the Study of Organisational and Interorganisational Dynamics. *Administration and Society*, 5, 588-615.
- BURNS, N., & GROVE, S., K., 2001. *The Practice of Nursing Research Conduct Critique and Utilization* Philadelphia W., B., Saunders Company.
- BUSCH, F., N., & MILROD, B., I., 2010. The ongoing struggle for psychoanalytic research: Some steps forward. *Psychoanalytic Psychotherapy*, 24, 306–314.
- CAMERON, D., & KAPUR, R., 2005. Releasing the therapeutic potential of the psychiatric nurse: a human relations perspective of the nurse-patient relationship. *Journal of Psychiatric and Mental Health Nursing*, 12, 64-74.
- CHALMERS, A. F. 1982. *What is this thing called Science?*, Milton Keynes, Open University Press.
- COLLIGAN, M., J., & AND MURPHY, L., R. 1979,. Mass psychogenic illness in organizations: An overview. *Journal of Occupational Psychology*, , 52, , 77-90.
- COMERFORD, H. 2010. 'Creatures of Each other'? *Reflections On The Mutuality Of The Construction Of Boundaries/Barriers Between Society And The Mentally Ill* [Online]. <http://www.isop.org/Symposia/Melbourne/Comerford.htm>. [Accessed 15/05/2010 2010].
- CONNOLLY, H. 1980. The Scandal of the Mental Hospitals. Magill
- CROWE, K. 2004a. What we heard – A Report on the Service Users Consultation Process. . In: CHILDREN, D. O. H. A. (ed.). Dublin: Expert Group on Mental Health Policy Government of Ireland.
- CROWE, M. 2004b. The place of the unconscious in mental health nursing. *International Journal of Mental Health Nursing*, 13, 2-8.
- CUTCLIFFE, J. R. A. W., M. 2003. *Critiquing Nursing Research*, London, Quay Books.
- DALY, A., & WALSH, D., 2009. Activities of Irish Psychiatric Units and Hospitals 2008. *HRB Statistics Series*. Dublin: Health Research Board.
- DALY, A., & WASH, D. 2011. Activities of Irish Psychiatric Units and Hospitals 2010 Main Findings. *HRB Statistics Series 15*. Dublin: Health Research Board.
- DALY, G. 1999. Politics and the Impossible: Beyond psychoanalysis and deconstruction. *Theory Culture and Society*, 16, 75-98.
- DAVIS, K., C., 2003. An Ethnography of Political Identification: The Birmingham School Meets Psychoanalytic Theory. *Journal for the Psychoanalysis of Culture and Society*, 8, 3-11.
- DE MIJOLLA, A. (ed.) 2005. *International Dictionary of Psychoanalysis*: Thomson Gale.
- DEBOARD, R. 2005. *The Psychoanalysis of Organizations*, London, Routledge.
- DIAMOND, M. A. 1993. *The Unconscious Life of Organizations. Interpreting Organisational Identity*, London, Quorum Books.
- DONNE, J. 1624. Devotions Upon Emergent Occasions, Meditation XVII: Nunc Lento Sonitu Dicunt, Morieris. <http://www.phrases.org.uk/meanings/for-whom-the-bell-tolls.html>: The Phrase Finder.

- DOSAMANTES-BEAUDRY, I. 2007. Somatic Transference and Countertransference in Psychoanalytic Intersubjective Dance/Movement Therapy. *American Journal of Dance Therapy*, 29, 73-89.
- DRAVERS, P. 2004. To Poe, Logically Speaking: From 'The Purloined Letter' to the Sithome. In: RAGLAND, E., & MILOVANOIC, D. (ed.) *Lacan: Topologically Speaking*. New York: Other Press.
- DRESSER, I. 1985. Developemnt Of The Concept Of Transference And Counter-Transference. *Psychoanalytic Psychotherapy*, 1, 13-23.
- EDGINTON, S. 1998. A Therapeutic Journey. *Open Mind*, 31, 14-16.
- ELLIOTT, A. 1992. *Social Theory and Psychoanalysis in transitioin: Self and Society from Freud to Kristeva*, Oxford, Blackwell.
- ERLICH-GINOR, M., & ERLICH, S. 1998. Mental Health under Fire: Organizational Interventions in a Wounded Service. Available: <http://www.isop.org/Symposia/Jerusalem/1998erlich-ginor.htm> [Accessed 14/05/2010].
- ESTROFF, S. E. 1985. *Making it Crazy - An Ethnography of Psychiatric Clients in an American Community*, Berkeley and Los Angeles, University of California Press.
- EVANS, D. 2005. *An Introductory Dictionary of Lacanian Psychoanalysis*, London and New York, Routledge
- EXPERT GROUP ON MENTAL HEALTH POLICY 2006. A Vision for Change - Report of the Expert Group on Mental Health Policy,. In: DEPARTMENT OF HEALTH AND CHILDREN (ed.). Dublin: The Stationary Office.
- FENICHEL (1946) CITED IN MENZIES LYTH, I. 1989. *The Dynamics Of The Social Selected Essays*, London, Free Association Books
- FINK, B. 1995a. *The Lacanian Subject Between Language and Jouissance*, Chichester United Kingdom, Princeton University Press.
- FINK, B. 1995b. *The Lacanian Subject Between Language and Jousissance*, Princeton New Jersey, Prinction University Press.
- FINK, B. 1999. *A Clinical Introduction to Lacanian Psychoanalysis Theory and Technique*, Cambridge, Maassachusetts, Harvard University Press.
- FINK, B. 2007. *Fundamentals of Psychoanalytic Technique*, London, W.W. Norton and Company.
- FISHER, S., & GREENBERG, R., P., 1996. *Freud scientifically reappraised. Testing the theories and therapy*, New York, Wiley.
- FLINT, D. 2010. Florence Nightingale - The Lady With the Lamp. *Historical iographies@suite101* [Online]. Available: <http://suite101.com/article/florence-nightingale---the-lady-with-the-lamp-a249585> [Accessed 14.06.12].
- FONAGY, P. 2000. Grasping the Nettle: Or Why Psychoanalytic Research is Such an Irritant. In: THE BRITISH PSYCHOANALYTIC SOCIETY (ed.). <http://www.pschoanalysis.org.uk/fonagy1.htm>.
- FOTAKI, M. 2010. Why do public policies fail so often? Exploring health policy making as an imaginary and symbolic construction. *Organisation*, 17, 703-720.
- FOUCAULT, M. 1975. *Birth of the Clinic, The Archaeology of Medical Perception*, New York, Vintage Books.
- FOUCAULT, M. 2006. *History of Madness*, London, Routledge.
- FREUD, S. 1893-1895. *The Psychotherapy of Hysteria*. London: Vintage Hogarth Press.
- FREUD, S. 1900. *The Interpretation of Dreams*, London, Vintage Hogarth Press.
- FREUD, S. 1901-1905. *A Case History of Hysteria, Three essays on Sexuality and Other Works*, London, Vintage Hogarth Press.

- FREUD, S. 1905a. Fragment of an analysis of a case of hysteria. *A Case of Hysteria, Three Essays on Sexuality and Other Works*. London: Vintage Hogarth Press.
- FREUD, S. 1905b. Pleasure and the Gain of Jokes. *Jokes and their Relation to the Unconscious*. London: Vintage Hogarth Press.
- FREUD, S. 1905c. *Three Essays on the Theory of Sexuality*, London, Hogarth Press.
- FREUD, S. 1907. *The Freud/Jung Letters: The Correspondence Between Sigmund Freud and C. G. Jung*, New Jersey Princeton University Press.
- FREUD, S. 1909. *Two Case Histories: 'Little Hans' and the 'Rat Man'*, London, Vintage Hogarth Press.
- FREUD, S. 1911-1913. *Case History of Schreber, Papers on Technique and Other Works*, London, Vintage Hogarth Press.
- FREUD, S. 1911-1915. Papers on Technique. In: STRACHEY, J. (ed.) *The Case of Schreber Papers on Technique and Other Works*. London: Hogarth Press.
- FREUD, S. 1912. The Dynamics of Transference. *Case History of Schreber, Papers on Technique and Other Works*. London: Vintage Hogarth Press.
- FREUD, S. 1913a. The claim of Psychoanalysis to the interest of the non-psychological sciences. In: . (ed.) *Totem and Taboo and Other Works*. London: Vintage The Hogarth Press.
- FREUD, S. 1913b. *On Beginning The Treatment*, London, Vintage The Hogarth Press.
- FREUD, S. 1913-14. Totem and Taboo. *Totem and Taboo and Other Works* London: Vintage Hogarth Press.
- FREUD, S. 1914a. On Narcissism: An Introduction. *An Infantile Neurosis and Other Works*. London: Vintage Hogarth Press.
- FREUD, S. 1914b. Remembering, Repeating and Working-Through. *Case Histories of Schreber, Papers on Technique and Other Works*. London: Vintage Hogarth Press.
- FREUD, S. 1915a. Instincts and Their Vicissitudes. *On the History of the Psychoanalytic Movement Papers on Metapsychology and Other Works*. 1957 ed. London The Hogarth Press.
- FREUD, S. 1915b. Observations on Transference-Love. *Case Histories of Schreber, Papers on Technique and Other Works*. London: Vintage Hogarth Press.
- FREUD, S. 1915c. Repression. *A History of the Psychoanalytic Movement, Papers on Metapsychology and Other Works* London: Hogarth Press.
- FREUD, S. 1917a. A Difficulty in the Path of Psychoanalysis. *An Infantile Neurosis and Other Works*. London: Vintage Hogarth Press.
- FREUD, S. 1917b. Transference. *Introductory Lectures on Psychoanalysis (Part III)*. London: Vintage The Hogarth Press.
- FREUD, S. 1920. Beyond the Pleasure Principle. *Beyond the Pleasure Principle Group Psychology and Other Works*. London: Vintage Hogarth Press.
- FREUD, S. 1921a. Group Psychology and the Analysis of the Ego. *Beyond the Pleasure Principle Group Psychology and Other Works*. London: Vintage Hogarth Press.
- FREUD, S. 1921b. Preface to J.J. Puntman's Address on Psychoanalysis. *Beyond the Pleasure Principle Group Psychology and Other Works*. London: Vintage Hogarth Press.
- FREUD, S. 1923. The Ego and the Id. *On the History of the Psychoanalytic Movement Papers on Metapsychology and Other Works*. London: Vintage Hogarth Press.
- FREUD, S. 1923 Two Encyclopaedia Articles. *Beyond the Pleasure Principle Group Psychology and Other Works* London: Vintage The Hogarth Press.

- FREUD, S. 1937a. Analysis Terminable and Interminable. *Moses and Monotheism An Outline of Psychoanalysis and Other Works* London: Vintage Hogarth Press.
- FREUD, S. 1937b. Analysis Terminable and Interminable. *Moses and Monotheism, An Outline of Psychoanalysis and Other Works* London: Vintage The Hogarth Press.
- FREUD, S. 1937-1939. *Moses and Monotheism, An Outline of Psychoanalysis and Other Works*, London, Vintage The Hogarth Press.
- The Asylum*, 2005a. DVD. Directed by GILESAN, A. Ireland: Yellow Asylum Film Production for RTE
- Episode II Fallen Angels* 2005b. DVD. Directed by GILESAN, A. Ireland: Yellow Asylum Film Production for RTE
- GLYNOS, J., & STAVRAKAKIS, Y. 2002. *Lacan and Science* London, Karnack.
- GOERING, P., N., & STREINER, D., L. 1996. Reconcilable Differences: The Marriage of Qualitative and Quantitative Methods. *Canadian Journal of Psychiatry*, 41, 491-497.
- GOFFMAN, E. 1961. *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* New York, Doubleday Anchor.
- GOLDSTEIN, E., G., 2009. The Relationship Between Social Work and Psychoanalysis: The Future Impact of Social Workers. *Clinical Social Work Journal*, 37, 7-13.
- GORDON, J., HARDING, S., MILLER, C., & XENITIDIS, K., 2005. X-treme Group Analysis: On the Countertransference Edge in Inpatient Work with Forensic Patients. *Group Analysis*, 38, 409-427.
- GOVERNMENT OF IRELAND 1945. Mental Treatment Act. In: DEPARTMENT OF HEALTH (ed.). Dublin The Stationary Office.
- GOVERNMENT OF IRELAND 1982. *Planning for the Future*, Dublin, The Stationary Office.
- GOVERNMENT OF IRELAND 2001a. *Mental Health Act*, Dublin, The Stationary Office.
- GOVERNMENT OF IRELAND 2001b. *Report of the Inspector of mental hospitals for the year ending 31st December 2000.*, Dublin, Stationary Office.
- GOVERNMENT OF IRELAND 2006. A Vision for Change Report of the Expert Group on Mental Health Dublin: Stationary Office.
- GRANT, J., & CRAWLEY, J., 2003. *Transference and Projection*, Maidenhead, Open University Press.
- GREENSON, R. 1967. *The Technique and Practice of Psychoanalysis*, New York, International University Press.
- GRIGG, R. 2001. Discourse. In: GLOWINSKI, H., MARKS, Z., & MURPHY, S., (ed.) *A Compendium of Lacanian Terms*. London: Free Association Books.
- GYLOS, J. 2002. Theory and Evidence in the Freudian Field from Observation to Structure In: GLYNOS, J. S., Y., (ed.) *Lacan and Science*. London: Karnack.
- HARARI, R. 2001. *Lacan's Seminar On 'Anxiety'*, New York, Other Press.
- HARPERCOLLINS 2003. *Collins Paperback English Dictionary*, Glasgow, HarperCollins.
- HEALTH SERVICES EXECUTIVE 2012. A Vision for Psychiatric/Mental Health Nursing. Dublin: Health Services Executive.
- HOGAN, M., F., 1999. Public-sector mental health care: New challenges. *Health Affairs*, 18, 106-111.
- HOLLWAY, W., & JEFFERSON, T., 2007. *Doing Qualitative Research Differently, Free association, Narrative and the Interview Method*, London, Sage.

- HOLMES, C., A., & WARELOW, P., 1999. Implementing psychiatry as risk management: DSM-IV as a postmodern taxonomy. *Health, Risk and Society*, 1, 197-178.
- HOWITT, D., & CRAMER, D., 2005. *Introduction to Research Methods in Psychology*, Harlow England, Pearson.
- HYLDGAARD, K. 2004. The Conformity of Perversion *LACANIAN INK* [Online]. Available: <http://www.lacan.com/conformerper.htm> [Accessed 12/05/12].
- INSPECTOR OF MENTAL HEALTH SERVICES 2008. Report of the Inspector of Mental Health Services 2008 Dublin: Mental Health Commission.
- JOINER, T., E., JR., & KATZ, J., 1999. Contagion of depressive symptoms and mood: Meta-analytic review and explanations from cognitive, behavioral, and interpersonal viewpoints. *Clinical Psychology: Science and Practice*, 6, 149-164.
- JOSEPH, B. 1985. Transference: The Total Situation. *International Journal of Psychoanalysis*, 447-454.
- KANTER, J. 2007. Compassion Fatigue and Secondary Traumatization: A Second Look. *Clinical Social Work Journal*, 35, 289-293.
- KAVANAGH, A., & WATTERS, L., 2010. Consultant psychiatrists' experience of workplace violence—A national survey. *Irish Journal of Psychological Medicine*, 27, 77-81.
- KEOGH, F. 2002. Developments and challenges in mental health services in Ireland. *Mental Health Commission. Annual Report: 2002*. Dublin: Mental Health Commission.
- KLEIN, M. 1952. The Origins of Transference. *Int. J. Psycho-Analysis* 33, 433-438.
- KLEIN, M. 1998. *Love, Guilt and Reparation and Other Works 1921-1945*, London, Vintage Hogarth Press.
- KRUGER, B. 2010. *The Art History Archive Barbra Kruger* [Online]. <http://www.arthistoryarchive.com/arthistory/feminist/Barbara-Kruger.html>. [Accessed 04.10.2010 2010].
- KUHN, T., S., 1970. *The structure of scientific revolutions*, Chicago, University of Chicago Press.
- KVALE, S., & BRINKMANN, S. 2009. *Interviews Learning the Craft of Qualitative Research Interviewing*, Los Angeles, Sage.
- LA TALOVA, K., & PRAS, J., 2010. Aggression in Borderline Personality Disorder. *Psychiatric Quarterly*, 81, 239-251.
- LACAN, J. 1959-1960. *The Ethics of Psychoanalysis*, London, Routledge.
- LACAN, J. 1960-1961. Transference. In: UNEDITED (ed.) *The Seminar of Jacques Lacan Book VIII*. <http://www.lacaninireland.com/web/>; Gallagher, C.
- LACAN, J. 1977. The Function and Field of Speech and Language in Psychoanalysis. *Écrits A Selection*. London: Tavistock/Routledge.
- LACAN, J. 1988a. *The Seminar Book II. The Ego in Freud's Theory and in the Technique of Psychoanalysis, 1945-55*, Cambridge, Cambridge University Press.
- LACAN, J. 1988b. *Seminar I: Freud's Papers on Technique* Cambridge, Cambridge University Press.
- LACAN, J. 1988c. *Seminar II The Ego in Freud's Theory and in the Technique of Psychoanalysis* Cambridge, Cambridge University Press.
- LACAN, J. 1993a. *ÉCRITS A Selection.*, London, Routledge Press
- LACAN, J. 1993b. *Seminar III: The Psychosis*, New York, W.W. Norton.
- LACAN, J. 1994. *The Four Fundamental Concepts of Psycho-Analysis*, London, Penguin Books.
- LACAN, J. 1997. *The Psychosis*, New York, W. W. Norton and Company.

- LACAN, J. 2007. *The Other Side of Psychoanalysis*, London, W W Norton & Company.
- LACAN, J. 2008. *My Teaching*, London, Verso.
- LAPLANCHE, J., & PONTALIS, J.B., 1988. *The Language of Psychoanalysis*, London, Karnac Books.
- LEADER, D., & GROVES, J., 1995. *Lacan for Beginners*, Cambridge, Icon Books.
- LIBBRECHT, K. 2001a. Imaginary. In: GLOWINSKI, H., MARKS, Z., & MURPHY, S., (ed.) *A Compendium of Lacanian Terms*. London: Free Association Books.
- LIBBRECHT, K. 2001b. Symbolic. In: GLOWINSKI, H., MARKS, Z., & MURPHY, S., (ed.) *A Compendium of Lacanian Terms*. 1 ed. London: Free Association Books.
- LIEVROUW, A. 2003a. Psychoanalysis and Research: a Matter of Ethics. *The Letter*
- LIEVROUW, A. 2003b. Psychoanalysis and Research: a Matter of Ethics *The Letter* 28 & 29.
- LONG, S., & NEWTON, J., 1997. Collaborative Action Research in an Organisation: Can Psychoanalytically Informed Thinking Deepen the Collaboration? *14th Annual Meeting of the International Society for the Psychoanalytic Study of Organizations*. Philadelphia, PA isps Library.
- LOOSE, R. 2002. *The Subject of Addiction*, London, Karnac.
- LUBAN-PLOZZA, A. 1995. Empowerment techniques: from doctor-centered (Balint approach) to patient-centred discussion groups. *Patient Education and Counselling*, 26, 257-263.
- MAHONY, P., J. 2000. Freud's Unadorned and Unadornable: A Case History Terminable and Interminable. *Psychoanalytic Inquiry*, 27-43.
- MAIN, T. 1957. *The Ailment*, New York, New York University Press.
- MARSHALL, J. 2003. Nervous Dramaturgy: Pain, Performance and Excess in the Work of Dr Jean-Martin Charcot, 1862-1893. *Art and Pain* [Online]. Available: http://www.doubledialogues.com/archive/issue_four/marshall.htm [Accessed 16.06.10].
- MAUSS, M. 1923. *The Form and Reason for Exchange in Archaic Societies*, London, Routledge
- MCLEOD, J. 2002. *Qualitative Research in Counselling and Psychotherapy*, London, Sage Publications.
- MEEHAN, M., & REGAN, R. 2010. Sean-nos Dancing. Available: <http://www.seannosdance.com/About/index.html> [Accessed 15/11/10].
- MENTAL HEALTH COMMISSION 2009. Bulletin. Dublin: http://www.mhcirl.ie/MHC_e-bulletin_Spring_2009.pdf.
- MENTAL HEALTH COMMISSION 2012. Standards & Quality Assurance. Mental Health Commission.
- MENZIES LYTH, I. 1988. *Containing Anxiety in Institutions Selected Essays*, London, Free Association Books.
- MENZIES LYTH, I. 1989. *The Dynamics Of The Social Selected Essays*, London, Free Association Books
- MENZIES. I. 1970. *The Function of Social Systems as a Defence Against Anxiety. Containing Anxiety in Institutions Selected Essays*, London, Free Association Books.
- MILLER, E. J., & GWYNNE, G.V., 1972. *A Life Apart*, London, Tavistock Publications.
- MITCHELL, J. R., J., (ed.) 1951. *Intervention on Transference*, New York: Norton.

- MONCAYNO, R. 2008. *Evolving Lacanian Perspectives for Clinical Psychoanalysis*, London, Karnac.
- MOORE, G. 2009. Presenting Case Material. *The Review*. Dublin: APPI.
- MOORE, G. 2011. In Conversation: Dr Pat Bracken speaks to Gerry Moore. *The Review*. Dublin: APPI.
- MORSE, J. M. 1999. Qualitative generalisability. *Qualitative Health Research*, 9, 5-6.
- MOYLE, W. 2003. Nurse-patient relationships: a dichotomy of expectations. *International Journal of Mental Health Nursing*, 12, 103-109.
- MURPHY, E., DINGWALL, R., GREATBATCH, D., ET AL., 1998. Qualitative Research Methods in Health Technology Assessment: A Review of the Literature. *Health Technology Assessment*, 16.
- NATIONAL JUSTICE CHIEF EXECUTIVE OFFICERS' GROUP AND THE VICTORIAN GOVERNMENT DEPARTMENT OF JUSTICE 2010. Diversion and support of offenders with a mental illness. Guidelines for best practice. State of Victoria: Victorian Government
- NEVILLE, D. 2010. *Adjournment debate: Mental Health Services* [Online]. Dublin: Government of Ireland. Available: <http://debates.oireachtas.ie/dail/2011/07/20/00031.asp> [Accessed 08/07/10 2010].
- NICOLAI DE CUSA OPERA OMNIA 1985. On Learned Ignorance (De Docta Ignorantia). 2 ed. Minnesota: The Arthur J. Banning Press,.
- NIXON, M. 2005. On the Couch. *October*, 113, 39-76.
- NOBUS, D. 2002. *Jacques Lacan and the Freudian Practice of Psychoanalysis*, London, Routledge.
- NOVIE, G. 2008. Jacques Lacan and the Other Side of Psychoanalysis: Reflection on Seminar XVII (Book Review). *Division 39* [Online]. Available: <http://www.apadivisions.org/division-39/publications/reviews/other.aspx> [Accessed 30.06.12].
- O'KELLY, G. 1998. Countertransference in the nurse-patient relationship: a review of the literature. *Journal of Advanced Nursing*, 28.
- ORGANISATION., W. H. 2001. Mental Health; New Understanding, New Hope. Geneva: World Health Organisation.
- PARKER, I. 1992. *Discourse Dynamics: Critical Analysis for Social and Individual Psychology*, London, Routledge.
- PARKER, I. 2005a. Lacanian Discourse Analysis in Psychology: Seven Theoretical Elements. *Theory & Psychology*, 15, 163-182.
- PARKER, I. 2005b. Lacanian Discourse Analysis in Psychology Seven Theoretical Elements. *Theory and Psychology*, 15, 163-182.
- PARKER, I. 2008a. Psychoanalytic Theory and Psychology: Conditions of Possibility for Clinical and Cultural Practice. *Theory & Psychology*, 18, 147-165.
- PARKER, I. 2008b. Psychoanalytic Theory and Psychology. *Theory and Psychology*, 18, 147-165.
- PDM TASK FORCE 2006. *Psychodynamic Diagnostic Manual*, Silver Spring MD, Alliance of Psychoanalytic Organisations.
- PELED, A. 2008. *Neuroanalysis Bridging the gap between Neuroscience, Psychoanalysis and Psychiatry*, London, Sage.
- Every Little Thing (La Moindre des choses)*, 1996. DVD. Directed by PHILBERT, N. France: Second Run Ltd.
- POLICY., E. G. O. M. H. 2005. Speaking Your Mind A Report on the Public Consultation Process Dublin.

- POLKINGHORNE, D., E. 1995. Narrative configuration in qualitative analysis. *In:* HATCH, J. A. W., R., (ed.) *Life History and Narrative*. London: Falmer.
- RABATE, J., M. 2003. *The Cambridge Companion to Lacan*, Cambridge, Cambridge University Press.
- RAGLAND, E., & MILOVANOIC, D. 2004. Topologically Speaking. *In:* RAGLAND, E., & MILOVANOIC, D., (ed.) *LACAN: Topologically Speaking*. New York: Other Press.
- REGGIO, D., & NOVELLO, M. 2007. An Interview with Dr. Jean Oury. *Radical Philosophy*, 32-46.
- RENNIE, D. L. 1992. Qualitative analysis of the client's experience of psychotherapy: the unfolding reflexivity. *In:* TOUKMANIAN, S. G. R., D.L., (ed.) *Psychotherapy Process Research: Paradigmatic and Narrative Approaches*. London: Sage.
- RICHTER, D., NEEDHAM, I., KUNZ, S. 2006. The effects of aggression management training for mental health care and disability care staff: a systematic review. *Springer*, 211-227.
- ROBINS, J. 1986. *Fools and Mad A History of the Insane in Ireland*, Dublin, Institute of Public Administration
- ROBINSON, D. 1996a. Measuring psychiatric nursing interventions: how much care is individualised. *NT Research*, 1, 13-21.
- ROBINSON, D. 1996b. Observing and describing nursing interactions. *Nursing Standard*, 13, 34-38.
- ROGERS, A., & PILGRIM, D. 2005. *A Sociology of Mental Health and Illness*, Maidenhead, Open University Press.
- ROGERS, C. 2004. *On Becoming a Person A Therapist's View of Psychotherapy*, London, Constable.
- ROSENHAN, D., L. 1973. On Being Sane in Insane Places. *Science*, 179 250-258.
- ROUDINESCO, E. 2005. *Jacques Lacan An Outline of a Life and a History of a System of Thought*, Cambridge, Polity Press.
- ROUS, E., & CLARK, A. 2009. Child Psychoanalytic Psychotherapy in the UK National Health Service: an Historical Analysis. *History of Psychiatry*, 20, 442-456.
- ROWAN, A. 2000. The Place of Acting Out in Psychoanalysis: From Freud to Lacan. *Psychoanalytic Perspectives*, 41/42, 83-100.
- RYAN, A. 1999. *Walls of Silence*, Callan, Red Lion Press.
- SALINSKY, J. 2002. The Balint Movement Worldwide: Present State and Future Outlook: A Brief History Of Balint Around The World. *The American Journal of Psychoanalysis*, 62, 327-335.
- SALIZE, H., J., DREßING, H., & PEITZ, M. 2002. Compulsory Admission and Involuntary Treatment of Mentally Ill Patients – Legislation and Practice in EU-Member States. Mannheim, Germany: European Commission - Health & Consumer Protection Directorate-General.
- SANDELL, R. 2001. Can Psychoanalysis Become Empirically Supported? *International Forum Psychoanalysis*, 10.
- SANDELOWSKI, M. 1997 "To be of use": Enhancing the utility of qualitative research. *Nursing Outlook*, 45, 25-32.
- SCHACTER, D., GILBERT, D., & WEGNER, D. 2012. *Psychology*, London, Palgrave Macmillan.
- SCHEPER-HUGHES, N. 2001. *Saints, Scholars, and Schizophrenics Mental illness in Rural Ireland*, Berkeley, University of California Press.
- SHAKESPEARE, W. 1593. The Sonnets. CRW Publishing LTD London.

- SHERIF, M. 1972. Experiments in Norm Foundation. In: HOLLANDER., E., P., & HUNT, R., G., (ed.) *Classic Contributions to Social Psychology*. London: Oxford Press.
- SHUR, R. 1994. *Counter-transference Enactment How Institutions and Therapist Actualize Primitive Internal Worlds* London, Jason Aronson INC.
- SKELTON, R., M. (ed.) 2006. *The Edinburgh International Ecyclopaedia of Psychoanalysis* Edinburgh: Edinburgh University Press.
- SMITH, T. W., NEALY, J.B., & HAMANN, H.A. 2000. *Health Psychology*, New York, John Wiley & Sons Inc
- SNOWDEN, R. 2006. *Teach Yourself Freud*, London, Hodder Education.
- STRAUSS, A. C., J. 1990. *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*, London, Sage.
- SULLIVAN, P. 1998. Therapeutic Interventions and Mental Health Nursing. *Nursing Standard*, 12, 39-42.
- TAYLOR, M. 2006a. Ethnography. *Qualitative Methods in Psychology*. 1st ed. Maidenhead United Kingdom: Open University Press.
- TAYLOR, S. 2006b. *Ethnographic Research A Reader*, London, Sage.
- THE ASSOCIATION FOR PSYCHOANALYSIS AND PSYCHOTHERAPY IN IRELAND 2008. Code of Ethics. <http://www.appi.ie/>: APPI.
- VANHEULE, S., & VERHAEGHE, P. 2002. Qualitative Research and Its Relation to Lacanian Psychoanalysis. *Journal for the Psychoanalysis of Culture and Society*, 7, 336-342.
- VANHEULE, S., & VERHAEGHE, P. 2003. 'Slave labour and mastery': A psychoanalytic study of professional burnout Doctor in der Psychologische Wetenschappen University of Ghent.
- VERHAEGHE, P. 2009. *new studies of old villians. A Radical Reconsideration of the Oedipus Complex*, New York, Other Press.
- VERHAEGHE, P. 2004. *On Being Normal and Other Disorders*, New York, Other Press.
- VERHAEGHE, P. 2007. Chronicle of a death foretold: the end of psychotherapy. *Health4Life*. Dublin City University: <http://www.dcu.ie/health4life/conferences/2007/Paul%20Verhaeghe.shtml>.
- WAJCMAN, G. 2003. *The Hysteric's Discourse* [Online]. The Symptom online journal for lacan.com Available: <http://www.lacan.com/hystericdiscf.htm> [Accessed 03/12/10 2010].
- WALLACE, E., R. 1983. *Freud and Anthropology*, New York, International University Press, INC.
- WALTER VAN ZALK, M., H., KERR, M., BRANJE, S., J., T., & MEEUS, W., H., J. 2010. Peer Contagion and Adolescent Depression: The Role of Failure Anticipation. *Journal of Clinical Child & Adolescent Psychology*, 39, 837-848.
- WATSON, Z. 2004. Floating between Original and Semblance. In: RAGLAND, E., & MILOVANOIC, D., (ed.) *LACAN: Topologically Speaking*. New York: Other Press.
- WEISSTEIN, E., W. 2012. *Möbius Strip* [Online]. MathWorld--A Wolfram Web Resource: Wolfram MathWorld. Available: <http://mathworld.wolfram.com/MoebiusStrip.html> [Accessed 05.07. 2012].
- WILLIAMS, E. 1998. RESEARCH AND PARADIGMS. Available: http://www.umdj.edu/idsweb/idst6000/williams_research+paradigms.htm#Paradigm [Accessed 02.06.12].
- WINKLER, R., C. 1974. Research into mental health practice using pseudo-patients. *Medical journal of Australia* 14, 399-403.

WOLIN, R. 2010. History & Society: Pierre-Félix Guattari. *Encyclopædia Britannica*.
<http://www.britannica.com/EBchecked/topic/248068/Pierre-Felix-Guattari>:
Encyclopædia Britannica.
YEATS, W., B., 1926. Amongst School Children. <http://www.web-books.com/Classics/Poetry/Anthology/Yeats/Among.htm>: <http://www.web-books.com>.

Appendix A Section 33 of the Mental Health Act (Government of Ireland, 2001a).

‘Section 33(1) the principal functions of the Commission are to promote;
Appoint members of Mental Health Tribunals

- Establish a panel of consultant psychiatrists to carry out independent medical examinations of persons involuntarily admitted to approved centres
- Establish a legal aid scheme for persons involuntarily admitted to approved centres
- Appoint the Inspector of Mental Health Services
- Make Rules relating to the administration of Electro Convulsive Therapy
- Make Rules providing for the use of seclusion and mechanical means of bodily restraint on a patient
- Be notified of every decision to admit a patient involuntarily and every decision to extend the duration of a period of involuntary detention in an approved centre
- Appoint Mental Health Tribunals to automatically review the admission of every involuntary patient
- Arrange for a scheme for granting free legal aid to each patient whose involuntary admission is being reviewed by a Mental Health Tribunal
- Advise the Minister for Health and Children on a range of issues, including standards in approved centres
- Maintain a register of approved centres
- Prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in mental health services’, (Government of Ireland, 2001a)

Appendix B Field Note Template

Appendix C Abbreviations - Field Notes Table of Codes

Code	Role / Area
MSN	Male Staff Nurse
FSN	Female Staff Nurse
CNM1	Clinical Nurse Manager Grade 1
CNM2	Clinical Nurse Manager Grade 2
CNM3	Clinical Nurse Manager Grade 3
POA	Psychiatry of Old Age
DH	Day Hospital
AT	Art Teacher
ATH	Art Therapist
PAA	Patient Activity Area
AMA	Against Medical Advice
PT	Patient
STDN	Student Nurse
DREP	Drug Rep
Dr	Doctor
FAU	Female Admission Unit
MAU	Male Admission Unit

Appendix D Participants information sheet

Research Study Title: A PSYCHOANALYTIC INVESTIGATION OF TRANSFERENCE MANAGEMENT IN THE IRISH ADULT PUBLIC MENTAL HEALTH SERVICES

Conducted by: The School of Nursing, Dublin City University.

Principal Investigator: Prof. Chris Stevenson Tel: 7006581

Principal Researcher: Gerard Moore Tel: 7005340

Co-Investigators: Prof. John Cutcliffe, University of Texas, US.
Dr Rik Loose Dublin Business School

Summary:

This is a 3-year study which will examine how people talk and work in the mental health services. The study is concerned with trying to understand the effect the unconscious has on our day to day lives. In this study the effect of the unconscious will be looked at in relation to patient care by observing and interviewing people about how they relate to each other. The effect this has on patients and staff will be considered. Information for the study will be collected through published literature, television documentaries, watching people work and interviews. By learning more about how we react to each other it should be possible to suggest ways in which patient and staff satisfaction can be improved. As well as observing how people interact in the work place the researcher will be conducting a series of interviews. A selection of people will be interviewed by the researcher. The interview will be a one-to-one discussion with you about your experiences of services and your thoughts on what contributes to meaningful professional responses. Interviews will be held at a quiet and comfortable location as agreed between yourself and the researcher. Participation in these interviews is voluntary therefore you can decide to withdraw at any time during the interview process. If you withdraw from the interview you will not be discriminated against in any way and will be given equal access to information and services.

Benefits and Risks:

Potential benefits to Participants Include:

- The therapeutic effect of voicing your concerns and experiences to an interested party.
- Being provided with information about local services, which you may choose to access.
- Identifying your current needs and wishes and becoming engaged or reengaged with support structures and services as a result.
- Having a direct influence on developments that will guide professional practice and service provision.

Potential Risks to Participants Include:

- Becoming distressed in the interview by the recall of painful personal events and memories, which may lead to you requiring professional intervention.

In the event that you become distressed during your involvement in an interview for this study you may choose to or be advised to discontinue and will be supported to avail of suitable support systems. A supportive colleague and/or professionals involved with your care and treatment will be informed about your increased level of distress.

Anonymity and Confidentiality:

Anonymity of participants and confidentiality of interview material will be safeguarded through a number of measures, including:

- Recorded material will be transferred to a password computer package for storage and retrieval.
- Only those working on the research team, and named above, will have access to this material, as they will assist with directing the project in the most useful way on the basis of emerging issues.
- Signed consent forms will be stored in a locked filing cabinet and will not carry any identifying codes that connect individuals to specific recorded data.
- No information identifying an individual person or organization will be used in documentation pertaining to the study.

Study material will be subject to legal limitations, which means that it could be subject to subpoena, a freedom of information claim or mandated reporting by a professional. This would be necessary if you were assessed as being at risk of harm to yourself, or if you disclosed information that indicated that you presented a potential risk of harm, or had inflicted actual harm to another person.

NB If participants have concerns about this study and wish to contact an independent person, please contact:

The Secretary, Dublin City University Research Ethics Committee. C/o Office of the Vice-President for Research, Dublin City University, D. 9. Tel: 01-7008000

Appendix E Participant informed consent form

Research Study Title:

A psychoanalytic investigation of transference management in the Irish adult public mental health services

Purpose of Study:

The aim of this research is to investigate the management of transference and to make recommendation in relation to how recognition and management of transference would have positive outcomes for service users and providers.

Participation Requirements:

Potential participants will be invited to participate in a research interview. You will be asked to complete and sign this consent form and will be invited to partake in a one-to-one interview with the researcher. The interview will last between 45 – 60 minutes and will be recorded. You can decide on the nature and depth of information you share and you may terminate the interview at any time without explanation. If you choose to withdraw at any time in the study process you will be supported in this decision and will be given equal access to information and support services. The researcher may ask to meet you for a follow up interview to clarify information that you have shared.

Participant Confirmation:

(Please answer each question)

Have you read or had read to you the Information Sheet?

Yes/No

Do you understand the information provided to you?

Yes/No

Have you had any opportunity to ask questions and discuss the study?

Yes/No

Have you received satisfactory answers to your questions?

Yes/No

Are you agreeable to having your interview recorded?

Yes/No

Participant Signature:

I have read and understood the information in this form and the attached information sheet. My questions have been adequately answered by the researcher and I have a copy of the consent form. Therefore, I consent to participate in this research project.

Participants Signature: _____

Name in Block Capitals: _____

Witness: _____

Date: _____

Appendix F Memo acknowledging access to study site

Appendix G APPI code of ethics

The Association for Psychoanalysis and Psychotherapy in Ireland Ltd.

Code of Ethics and Practice

1. The Code of Ethics and Practice applies to those Members of the Association whose names appear on the Register of Practitioner Members and the Conditional Register. For ease of reading, the terms Psychotherapist and Psychotherapy specify Psychoanalytic Psychotherapists and Psychoanalytic Psychotherapy respectively. In turn, a psychoanalytic psychotherapist is a therapist whose practice is informed by the works of Sigmund Freud and Jacques Lacan. This amounts to defining the psychoanalytic psychotherapist as a specialised listener who gives a particular privilege to the place of the unconscious.

2. There is a central tension in psychotherapy between autonomy and dependency and this latter may be exploited by an unscrupulous psychotherapist. A core moral responsibility involves the promotion of the client's emotional autonomy, while conscientiously managing the peculiar but necessary psychological dependency of the client on the therapist in the course of treatment.

3. In all his/her work, the psychotherapist shall value integrity, impartiality and respect for all people who come to see him/her professionally. The therapeutic 'relationship' shall not be exploitative in any way. The psychotherapist shall hold the interest and welfare of those in receipt of his/her services to be paramount at all times.

4. (a) A psychotherapist shall not make claim directly or indirectly to qualifications, affiliations and capabilities which he/she does not possess.

(b) A psychotherapist shall take steps to monitor and develop his/her own competence and to work within the limits of that competence.

(c) All reasonable steps should be taken to ensure the safety of participants in psychotherapy.

(d) A psychotherapist shall ensure the confidentiality of information acquired through his/her practice and protect the privacy of individuals or organisations about whom information is known.

(e) A psychotherapist shall publish information about individuals, in oral or written form, only with their consent or where their identity is adequately disguised.

(f) Psychotherapists shall conduct themselves in their practice in a way that does not damage the interests of the recipients of their services or undermine public confidence in their ability to carry out their duties.

Specifically they shall:

(i) Refrain from practice when their physical or psychological condition seriously impairs their judgement.

(ii) Not exploit the special relationship of trust and confidence to gratify their personal desires.

(iii) Refrain from improper conduct that would be likely to be detrimental to the interests of the recipients of their services.

(iv) Neither attempt to secure or accept from those receiving their services any significant financial or material benefit beyond that which has been agreed.

(v) Not allow their responsibilities or standards of practice to be diminished by consideration of religion, sex, age, nationality, opinion, politics, social standing, class or other extraneous factors.

5. Where they suspect misconduct by a professional colleague which cannot be resolved or remedied after discussion with the colleague concerned, they may take steps to bring that misconduct to the attention of the Ethics Committee in accordance with the Articles of Association, doing so without malice and with no breaches of

confidentiality other than necessary to the operation of the proper investigatory procedure.

6. Psychotherapists shall take all reasonable steps to ensure that those working under their direct supervision comply with this Code.

