

ACP Annual Conference 2017

The whole is greater than the sum of its parts? - From psyche to society

Who do we think we are? The myth of the individual

Dr Sarah Sutton

sarahsutton@learning-studio.org

Abstract

In today's social and political context it seems more important than ever to understand not just the mechanisms but the roots of mental disturbance. Evidence from a number of disciplines, our own alongside child development research, neuroscience, biology and sociology shows the formative nature of relational experience. It becomes increasingly untenable to think of minds as an individual possession, each of us in the driving seat of our own little self vehicle (Eagleman, 2011). Yet as a society, we tend not to acknowledge this. The myth of the individual holds sway, in which the illusion is promoted that each of us is responsible for our behaviour and chooses a life path.

Here, I want to challenge this myth and show how it obscures the relational context. The neurobiologist Rose (2016) explains how gene research has made nonsense of the idea that there is a 'gene for' any particular human characteristic, from eye colour to IQ to sexual orientation. There is an alternative, more coherent way of making visible how minds are made. We are in fact social animals, in continual emotional and neurobiological call and response with the people around us, whether we know it or not. It makes evolutionary sense. We are born ready to adapt to the social and cultural norms of the world in which we find ourselves, and though a degree of brain plasticity continues, this adaptation sets our navigational course, our sense of meaning, informing the story of our lives.

I will begin by looking at some of the research on how relational experience frames identity and then consider some psychoanalytic concepts in this light, drawing on clinical material. I will also touch on group dynamics, the question of assumed identities and an increasing body of longitudinal research which suggests that mental health disturbance arises from disturbing relational experience. In conclusion, I will consider some implications for mental health policy.

Who do we think we are? The myth of the individual

A declaration of interdependence

Not the intense moment
Isolated, with no before and after,
But a lifetime burning in every moment
And not the lifetime of one man only
But of old stones that cannot be deciphered
T.S. Eliot (Four Quartets)

The last three decades of brain research have made T.S. Eliot's insight incontestable. We experience ourselves as separate individuals, but we are in fact profoundly shaped by the people around us, particularly our early relationships and their intergenerational influences. We have only to look at the Dutch hunger winter studies (Heijmansa, 2008), for example, to see that children and grandchildren suffer the consequences of a mother's hunger all their lives. Our ways of being, to our very core, can best be understood in the context of our family, indeed, of our family history. Undeciphered lifetimes burn in our every moment. In this paper I will try to show how we are wired by and for relating, and how it makes no sense to think of people as separate units, each in the driving seat of our own little self vehicle. As the neuroscientist Eagleman (2011) puts it in the introduction to his book, *Incognito*:

Your consciousness is like a tiny stowaway on a transatlantic steamship, taking credit for the journey without acknowledging the massive engineering underfoot.

I want to challenge the myth of the individual and show how it obscures the relational context which gives meaning to our thoughts, feelings and behaviour: Siegel's (2002) neurobiology of 'we'. We are social animals, in continual emotional and neurobiological call and response with the people around us, whether we know it or not. It makes evolutionary sense. We are born ready to adapt to the social and cultural norms of the world in which we find ourselves. "The most important job of the brain is to ensure our survival, even under the most miserable conditions" (van der Kolk, 2014:55). This adaptability is at the root of our species' success. Once adapted to our unique social context, we cannot stay this adaptable, it would be too time-consuming and in evolutionary terms would put us at risk: we need to learn the danger signals of our particular environment and act quickly - better wrong than dead. We find out what it is we need to do to belong and get protection; we cannot survive alone. This template, Bowlby's internal working model, or Stern's representation of interactions generalised (RIG), is quite hard to change, as here in this room we know, particularly if the circumstances were adverse (Sutton, 2014).

Having looked at the way in which relational experience frames identity, I will go on to consider key psychoanalytic ideas and some clinical material in this light, inevitably briefly in this context. I hope to show how the central concepts of transference, mourning and melancholia, and resistance are validated by the development research, and indeed gain new force.

These ideas, seen in the light of the insights from neurobiology and other disciplines, seem to me to have profound implications for therapeutic responses. As our understanding of what it is to be mentally ill changes to include the wired in relational context, we need to adapt our responses accordingly. I will consider in the final section the question of what we might be doing when we personalize mental health symptoms and promote the notion of individual resilience, and look briefly at approaches which take context into account. But to begin at the beginning...

How relational experience frames identity

There has been a great leap forward in neuroscience over the last two or three decades, establishing the fact that relationships are the medium through which minds are made:

Human relationships, and the effect of relationships on relationships, are the building blocks of healthy development. From the moment of our conception to the finality of death, intimate and caring relationships are the fundamental mediators of successful human adaptation. (Shonkoff & Phillips, 2000:27)

There is no such thing as a baby, as Winnicott knew, just as the idea of a mother involves at least two people. There is, rather, a constellation of care-giving which involves not only mother (in many cases) and baby, but also the wider social, emotional and economic relationships that the mother can draw on for support. The relationships in this whole support system are especially formative during our first two years or so, the period of greatest brain plasticity, as organisations like Parent Infant Partnership (PIP) UK attest.

During the critical first thousand days, the baby adapts to his or her own particular care world. Let's look briefly at how this process happens. As you will know, when a baby is born, the brain expands quickly as neural networks form, buzzing with energy as neurons seek input connections with other neurons. Over-production in the first two years is the brain's protection against uncertainty, maximising connection possibilities (Kolb & Gibb, 2011: 266). After this time the under-used excess begins to be pruned. This pruning to match environmental demands means that structure quickly fits experience.

We may well wonder what part genes play in this formative burst of activity. It seems that genes can influence behaviour, but cannot be separated from early experience. "There is abundant evidence that many genes require experience in order to be activated, and that one of the effects of experience on a developing organism is often to modify the activity of a gene" (Johnston, 2008: 22). Maternal postnatal depression and anxiety, (Atzil et al, 2011) as well as premature birth, stress and exposure to partner violence, can have this effect.

Whatever might be the appeal of the idea of the 'master gene', it has been discredited. Rose (2016) writes that with the discovery of the structure of DNA this view seemed possible, even likely. However, as it turned out, both the number and the nature of genes denied this possibility. We have twenty thousand, about the same number as a millimetre-long worm, to determine the fates of the tens of trillions of cells in the human body, let alone 'character'. Furthermore, genes are not 'master molecules' and do not operate but are operated on by cell enzymes. They are perhaps more to be seen as a potentiality than a blueprint, working not in isolation but as part of a dynamic collaboration, responsive to the environment, especially during the critical periods of gestation and early life (Szyf, 2009).

I want to look now a bit more closely at a vital component of our formative environment in this early period: our mother's state of mind. This, you could say, is the state in which we find ourselves. Another way of putting this is to say that her internal and external resources are crucial for her and for our well-being and furthermore, for our sense of self. In his book, *Affect Regulation and the Origin of the Self*, Schore (1994) has shown how the experience-dependent implicit self develops through right-brain-to-right-brain emotional resonance beginning at birth. He and others have studied this process in micro detail, in a way which does not delete meaning but underpins an understanding of how meaning is communicated emotionally. I will briefly outline it here, keeping in mind Bion's insight that the "thing-in-itself" - ultimate reality or "O" - is to be intuited through emotional experience.

Schore (1994) explains how implicit relational information "is transmitted in psychobiological exchanges embedded in the co-created attachment bond. During spontaneous right brain-to-right brain visual-facial, auditory-prosodic (Malloch & Trevarthen's 2010 communicative musicality), and tactile-proprioceptive emotionally charged attachment communications", the caregiver regulates the baby's states of arousal. He notes that implicit relational knowledge is not purely psychological but essentially psychobiological, mind and body. The rhythms of this exchange gradually lay down a pattern for emotional regulation in relationship, the musical signature of what happens, laying the groundwork for Stern's (1985) developing sense of self. The degree of sensitivity and attunement is therefore formative, validating

Winnicott's insight that the baby needs an ordinarily extraordinarily high degree of adaptation from the mother to begin with, in order to really flourish.

This then is how the baby comes to know him or herself, through the embodied emotional experience of this mutual resonance. In this sense, there really is no such thing as a baby. Who do we think we are? We learn who we are in a relational getting to know. Armstrong (1992:13) writes of Bion's interest in "the way naming has an illusory quality, as if it were felt to be the answer to a question, rather than the question for which an answer needs to be sought". The significance of the mother's state of mind will be apparent in this process of naming, of answering the question of who the baby is, of identifying a boundary which can be defended around the entity of ourselves (Armstrong, 1992).

In his book, *Mistaken Identity*, the neuroscientist Brothers (2001) shows just how fictional this boundary is, although we need it in order to conduct our lives. The notion of a mind of our own may be part of Armstrong's defensive barrier; what we call mind is shared between people in a continuing flow to and fro across the borders of the body (Siegel, 2007). The discovery of mirror neurons (Rizzolatti & Craighero, 2004) is important here. They not only fire when we plan an action ourselves, but also when we witness another's action. We feel what another feels: a step too near the cliff and an onlooker's hands get sweaty - even on television, or in a book. Maybe here are the roots of counter-transference; feelings that resonate with another's situation. Whose feelings are they? Mirror neurons mean that our boundaries cannot be so clearly drawn.

The evidence shows, for example, that babies of depressed mothers are in a state of heightened arousal, with elevated heart rates and cortisol levels (Field et al, 1988). We thus take in our mothers' state of mind, in a process that lays down the core of our sense of identity. Babies have no comparator, and so take in the isness of their being in the world in an undifferentiated way. To all intents and purposes to begin with, our mother's mind is the world in which we find ourselves. Her sense of who we are, her sense of the demands we are making upon her, the nature of her internal and external world and our place in it: these are formative as our mind makes connections - a million neural connections a second in the first thousand days.

A word about trauma, identity and relational development

In the child psychotherapy profession, we work a great deal with children who have suffered trauma, and are charged with making sense of their experience. We now have a tremendous resource at our disposal in the twenty-first century understandings that child development research brings, which Graham Music

has long highlighted and has made available in his book, *Nurturing Natures* (2010). We know, for example, that when a child is left in prolonged dysregulated states, is frightened, abused and/or neglected by his or her caregiver, this establishes ways of being that are dysregulated and not adapted to safety but to the failure of safety. It sets up sensory processing problems, and profoundly shapes the implicit, embodied sense of self. In this way, qualities of early experience become attributed to the child self, implicitly to begin with. This can then be compounded by explicit responses from the external world, confirming the feeling of "something's the matter with me"; not "something is disturbing me", but "I am disturbed".

Reinforcing this misattribution, children tend to experience what happened as their own fault. One reason for this is that they are dependent upon what Robin Balbernie (2002) has called their "scaregiver", and so holding a position of "It's not you, it's me" makes sense. It doesn't do to bite the hand that feeds you, particularly when nourishment is scarce and unpredictable. Through shame too and fear they tend to silence themselves or deny what happened. In addition, during traumatic events, higher brain areas are inhibited, preventing the traumatic experience from being brought into an explicit coherent narrative. Dissociated traumatic body memories are split off from conscious awareness and stored as sensory perceptions, dysregulated arousal, and behavioural re-enactments - the sort of symptoms for which children are referred for psychotherapy. Stimuli embedded in body memory trigger multimodal simulations throughout the body and brain to literally recreate lived experience (Rejeski & Gauvin, 2013). We are back with Freud, and the re-living of that which we cannot remember. The neuroscientist Joseph LeDoux (2002) links explicit and implicit aspects of the self with Freud's partition of the mind into conscious, preconscious and unconscious levels. Unconsciously, implicitly, we are what we have lived - especially when it is traumatic. The relational past is present.

We have seen that the human mind and sense of identity develops through relating; our social and emotional experience influences us at every level, from the cellular to the organisational. For good or ill in our early months we wire in a navigation system adapted to our social group as new neural pathways are formed in response to emotional and interpersonal stimuli. These connections are reinforced by use, and pruned through disuse. They guide us for the rest of our lives, particularly when we are under stress, and shape our sense both of who we are and of who we expect others to be. Here we have the neurobiological basis of transference. It is an adaptation to a particular early world. Later, I will consider some of the implications of this for understanding and responding to mental health symptoms, but first I would like to look more closely at links between recent neuroscience and psychoanalysis.

Some key psychoanalytic concepts in the light of development research

Many of Freud's great insights at the turn of the last century are illuminated by twenty-first century research. I will try and think a bit about the neurobiology of transference, mourning and melancholia and resistance in the space I have here.

Siegel's work (1999:30) establishes the mind as an "anticipation machine", supporting the psychoanalytic thinker Sandler's (1976) concept of "role-responsiveness", our tendency to evoke and supply the responses we intuit on both sides of the conversational encounter. Even in untraumatic, everyday situations, a delicate dance, mostly unconscious, ensues around the question, Who am I for you?

Ricky Emanuel (2004) gives a dramatic account of who he is for a boy he calls Michael, showing the impact of neurobiological responses wired in early. He writes of traumatic abuse stored as body memory, unavailable to narrative, and oblivious to time and place. When stress levels are high and too much cortisol is washing around, as Sue Gerhardt (2004) has explained, declarative memory is impaired. The amygdala response to a particular trigger activates the autonomic nervous system and a sensory and emotional flashback to the experience takes place out of time and out of conscious awareness. Michael's state of mind and body "meant that he was again, in the here-and-now, in the presence of a dangerous man" (Emanuel, 2004).

Most if not all child psychotherapists will have worked with children for whom the past is present in ways that feel dangerous. I remember an 8 year old girl telling me she saw the face of her abusive father on her adoptive father when he tried to restrain her. This particular girl, I'll call her Clare, was seen as aggressive and dangerous. Her adoptive father was described as having a "bottomless pit" of patience (which does not sound like a welcoming place to settle down in) and her adoptive mother often felt persecuted to the point of barricading herself in her room. The pattern seemed to be that all the hostility in the house was channelled through Clare.

This fitted Clare's experience; it felt much safer to her to be the aggressor than to be on the receiving end; and in her disruptive, dangerous early world, those were the only two options. There were powerful reasons for Dad's endless patience; his younger brother, with whom he had had a difficult relationship, had died in an accident, and Dad, seen in his family as the "good" son, the protective older brother, reproached himself. Mum was adapted to a family world in which she was picked on quite viciously by her mother. Transferring her hatred to her adoptive daughter: "You're the one persecuting me and making my life a misery", seemed to mean she could make some sort of

alliance with her mother. So Clare's rages established a kind of uneasy equilibrium in the family system. Furthermore, bringing Clare for therapy had the effect of locating the problem in her, protecting Dad's sense of himself as the patient, good one and Mum's as the innocent victim of an unfair attack; an arrangement that offered the grim satisfaction of maintaining the status quo, but was unlikely to lead to change.

What does it mean then to say that Clare is aggressive? It is a way of being that is adapted to an aggressive early world and has its uses now. I think a description of Clare as characteristically aggressive is understandable from her parents' point of view, but it is not the only way of seeing what is happening. She certainly knew about aggression, knew its power and could use it, but it is rather a characteristic of the unsafe world to which she is adapted, recreated now in her adoptive home and enacted by her parents who had their own reasons for joining in.

Writing about this interweaving picture brings to mind Louise Emanuel and her work in the Under-5s service, outlined in her book, *What can the matter be?* She understood the formative nature of early experience many years ago and spent the rest of her life encouraging us to focus our attention on children's early years. She saw symptoms not as a personal possession, but as dramatic enactments of the child's and family's predicament in the context of the wider intergenerational family system. Her paper, *Deprivation x three* (2002) describes how the disturbance ripples out into the professional network; troubled and troubling dynamics re-enacted around a child whose early life has been disturbing.

It seems appropriate to turn now from transference towards mourning and melancholia. There is not much scope here to consider these huge subjects, but I would like to touch briefly on the presence of absence in terms of the intersubjective neurobiology of mind. We have seen the reliving of untold stories neurologically confirmed, and the psychobiology suggests that when our relationship with primary figures is unresolved, unmediated by an available attuned mind, when it is not possible to relate to them, we embody them.

I worked for some years with a girl whom I'll call Belle, who was suffering from an eating disorder. She had been hospitalized at 11, and was scarily thin when she was discharged on the understanding she came to our clinic. We had a specialized eating disorder service, and there was much attention paid to her weight and to her eating, but the trouble turned out not to be about the food. She could not talk about a trauma she had suffered as a young girl when her father, with whom she was identified in the family, killed himself. I cannot do her justice here, but suffice it to say that she carried him with her; she embodied his depression and death until such time as she could begin to bear

to approach that grim experience. Until then, who did she think she was? I think she thought she was her dad, or at least the person re-presenting him in the family. I think she may have been seeking to find herself in his state of mind, facing self-inflicted death as he was. It was perhaps her way of keeping him close, and keeping him present in her mother's mind, too, for the couple had split shortly before he died. She could not bear to lose him, although she already had.

I am aware in writing this that we know it to be true; we work on this basis and have done for many years. I have a more modest aim, in the context of the cuts which have demoralised and often demolished our services, which is simply to widen our focus from the individual and make the links more explicit between our work and recent brain research. This research largely supports claims which may have been rejected by the scientific community in the past, but which are now coming into view as the cornerstone of any effective mental health treatment (Cozolino, 2010; Schore, 2012). The relational way in which we work is validated by the research - provided the symptom is not personalized. Belle was suffering from her family's lack of capacity to mediate her father's death, from a maternal mind which was teflon-coated as it were, hardened by Mum's own troubling experience, and experienced by our girl as convex, in Gianna Williams' (1997) term, rather than containing. The idea of the suicide had nowhere to go in the family, and so Belle carried it in her body. We do her a disservice, and risk reinforcing despair, if we treat it as a personal characteristic of her individual mind, rather than a communication of the state she finds herself in.

The work with Belle brings me onto the idea of resistance, for she certainly clung to that symptom for years in a way that sometimes became frankly tedious for me, as she paced silently in session after session after session. She seemed, in one way of framing my experience of her, to be utterly resistant to the prospect of getting better. However, I think getting to know a little bit about the neuroscience helped me bear the irritation. One of the effects of trauma on the brain is that neuronal pathways are intensively created in parts of the brain that stimulate hypervigilance - which makes sense, given that the brain develops adaptively in relation to the situation in which the baby finds him or herself. A hard-wired 'superhighway' develops, through which new experience is filtered. This is useful in a dangerous world, as was Belle's in her early years. However, it also means the parts of Belle's brain that process ordinary positive experience withered; they are not so vital for survival. This may present in the clinic as resistance to treatment, and risks being understood - if symptoms are framed as belonging to the individual - as a choice, at some level, of a -K link. Another way of seeing it though, is as a representation in and through her psychophysiological system of the world in which she finds herself, where links may be denied.

I felt that in embodying her suicidal father, there was a fierce loyalty not only to him, but to the missing vulnerable little girl she had once been, who bore the impact of that traumatic event without the availability of a mediating mind to witness her experience. However, even when we are witnessed, and someone tries to name our experience, we run into the difficulty of the gap between experience and language, Bion's (1970) illusion of naming.

Beyond the ordinary and inevitable scope for limitation we have the complexifying factor of distortion. Bion sees a lie, here we might say resistance, as sometimes used to maintain a barrier against elements that would lead to the emotional upheaval of 'catastrophic change'. In maintaining her symptom, Belle may well have been trying to protect her family system against catastrophic change - a change which, as Bion (1970) puts it 'outrages the moral system'. Moralizing is one form of regulation, and locating badness outside makes stability inside seem more achievable. This process happens in nations, of course - as it is now, in the US and the UK - in groups and organizations as well as between or within individuals. I would like to turn now to consider this relation between the symptom or state of mind and the social context.

Group dynamics & the question of assumed identities

Focusing on the symptom and not its use in the family/group context begins to look like negligence at best. The question of where the problem is located and who takes responsibility is a complex one, and worth a bit of examination I think. The relational roots of disturbed behaviour call into question the very nature of personal responsibility. For example, some time ago, a 15 year old boy who killed his teacher was sent for psychiatric assessment, which concluded that he was of sound mind during the attack, and so could be held responsible. What does it mean in this context to say he was of sound mind? This judgement ignores the neuroscience of how minds are wired, and evokes medieval notions of good and evil. Are we seriously suggesting he is intrinsically evil? You may as well say he was possessed by the devil: locate the badness in him and lock him up, thereby locking up the badness.

The boy is quoted as saying, "It was her or me". His feeling seems to have been that "her" survival was not compatible with his, and with the benefit of neuroscience/transference, we can take the "her" to stand for the prototype female figure in his mind. Some of the roots of this feeling may lie in postnatal experience, which for some mothers can feel just as extreme and polarized - It's the baby or me. If we take the relational root of the growth of mind seriously, and the neuroscience we have looked at here makes it hard to deny, the question of taking responsibility begins to look rather complex.

Brothers' book, *Mistaken Identity*, critiques neurologist's stories of unusual cases, suggesting that they offer a "profoundly unsettling" challenge to the assumption that "personhood is a given, external reality, independent of our own construction". Instead, these stories "confront us with the strangest reality of all - the reality of our construction of human life" (Brothers, 2001: 45). Children seem to know this; at least the children Gail Walker worked with did. Her paper, *Who'll be the naughty one now?* (Walker, 2005) describes a group of children asking that question when their usual 'naughty one' was away. In groups, we have states of mind going begging, a bit like Pirandello's (1921) characters in search of an author - who will take them on?

Perhaps there is a subtle or not so subtle negotiation that goes on in groups, including family groups, between the need to belong and the kind of role we are prepared to take on: Sandler's (1976) role-responsiveness. For one young person referred to me, whom I will call Kelly, a question about gender identity seemed to be part of this negotiation. In meeting with her parents, I had a sense of ways of being male or female in search of a home, ideas that went back generations through at least two distinct religious and national cultures. Her mother had always wanted to be the boy her own parents did not have, but was confused, upset and shamed by her daughter's wish to be treated as a boy. Kelly did not want physiological treatment, but felt all wrong in her figure and bound her breasts. She seemed to be representing something about the idea of a girl which was profoundly unacceptable in the family - unwanted, even perhaps despised, though not consciously. In response to my efforts to explore what it might be like to be a girl, Kelly talked about how what she hated was the bitchiness of girls, and how Dad was the worst one for that. All sorts of complex issues of endocrinology were no doubt involved, and I am barely skimming the surface here of the undercurrents in the family system, but somewhere there seemed to be the question of, *Who'll be the girl?* Only Dad seemed prepared to volunteer.

Cases of more consciously assumed identities are interesting in presenting us with evidence of what happens when boundaries of the self are explicitly constructed for a specific purpose, for example police undercover work. A couple of years ago the police had to pay heavy compensation to someone who had taken an undercover policeman at face value; had believed in his assumed identity to the extent of bearing his child. Given that he was present at the intensely real event of the birth, I can only assume that he believed in it too, if only partially; at the very least, when he was in character. This very real boy is born from a fictitious relationship. It raises the question, *Who is his father?* The answer depends on the context. In more ordinary ways, we feel ourselves to be different in different relational and social contexts, even when the assumption of identity is not a conscious falsehood. We are each to be

understood not "as an island entire of itself" but as "involved in mankind" in Donne's (1624) lovely phrase.

From the individual to the social: some implications of the shift in focus

The neurologist Damasio calls for a new understanding to "contribute to the effective treatment of some major causes of human suffering" (Damasio, 2003: 7). He asserts the value of understanding the links between feeling, brain and mind as "indispensable to the future construction of a view of human beings more accurate than the one currently available". This view would include our social interdependence. We have seen that we are profoundly social creatures, born ready to adapt to the environment of our early lives, and then largely navigating life by the light (or in the dark) of that context.

The Adverse Childhood Experience (ACE) study begun in the US in 1998 establishes a dose-response relationship between adverse childhood experiences and many health and mental health problems. Cumulative ACE scores mean maltreated children are as much as ten times more likely to develop alcoholism and/or depression, to use drugs, to attempt suicide, and to suffer serious physical disease (Felitti, 1998). Other studies have shown that vastly more children are locked up after suffering adversity; 90% of adolescents in US jails (Abran, 2004) had suffered at least one major trauma and many had PTSD symptoms. Our justice system is set up to see individuals as responsible for crimes, and yet it is not a coincidence that crime is highest in areas of most deprivation. Children growing up in the thirty most deprived local authorities in the UK have significantly worse developmental outcomes than those in the thirty least deprived areas (Index of Multiple Deprivation, 2015). Poverty is not the only form of adversity, but it has a huge relational impact. Balbernie (2016) has shown how poverty titrates stress into formative relationships. It has been identified as a negative predictive factor associated with a number of troubling outcomes, including adolescent criminality, school dropout, teen pregnancy and infant mortality (Ferguson, 2008:8).

The cumulative effect of adversity changes developmental paths, as the ACE study shows. Neurologically, if I am subjected to neglect, for example, I will have a significantly smaller brain, with abnormal development of the cortex, and hence will be subject to all kinds of social and emotional processing difficulties. This is not a character flaw. My recovery is age-dependent; the earlier my circumstances change, the better my chances, as we might expect. (Perry & Pollard, 1997). Perry and others (1995) outlined twenty years ago the process by which 'states' become 'traits'. I think we risk perpetuating something problematic if we attribute disturbed behaviour to the nature of a child, rather than to the nature of the child's early world. The research I have outlined briefly here means we cannot continue to personalize these outcomes.

Yet as a society, by and large, we are not prepared to know this. Instead, the myth of the individual holds sway, in which we promote the illusion that we are separate, that each of us is responsible for our own behaviour and chooses a life path. What are we doing when we ignore the evidence of the ACE study, for example, and insist on personal attribution? Why do we interpret depression, anxiety, suicide and self-harm in terms of individualized symptoms, and set up separate care pathways? Why do we continue to insist on the primacy of constitutional factors in the individual mind, given that we now know how minds are wired through relating and how harmful are the effects of adversity upon development in every possible way? More broadly, what is the role of therapy culture in social suffering? It may be that we have our own moralizing regulatory system in place, which resists disturbance. As McGilchrist (2009) has shown, the human mind - the left brain particularly - is not so much rational as rationalizing. If we can locate any quality, say madness or badness, in a personal, religious or national identity, confirmation bias will kick in and reinforce our beliefs, maintaining the status quo and eradicating disturbing elements that do not fit the picture we have in mind. Much public money is invested in attempts to resolve seemingly intractable recurrent mental health problems. I wonder if like Belle, as a society we do just enough not to face real change. Maybe this is the price we pay for preventing Bion's 'outrage' of change to our national moral system, the lie of meritocracy.

Whatever the unconscious rationale for resistance, it has become clear that attempts to understand and address mental health problems need to include the social, relational context. This is where psychoanalytic psychotherapy comes in. Freud's inspired free association technique turns out to be a very good way of getting to know someone's mind and early world, the connections that fired together and so wired together in their early years, their expectations of relationships, formed in the world of their primary relationships. There is no longer any doubt that psychotherapy can result in detectable changes in the brain (Etkin et al, 2005). Glass (2008:1589) writes that: "psychotherapy affects brain function and structure" in all kinds of helpful ways, including enhancing plasticity.

Using models of therapy that start early and take modern neurobiology into account is simply more efficient. Child psychotherapy is uniquely placed to offer this kind of help, trained as we are in taking the transference, even when - perhaps particularly when - it is hostile. Anne Alvarez (1992), Ann Hurry (1998), Vivianne Green (2003), Graham Music (2010) and others writing in the child psychotherapy tradition argue that a developmental element is inevitable and important. The notion of therapist as present "developmental object" (Hurry, 1992; Green, 2003) is predicated on an understanding of a deficit in the child's relationships. The limitation of the child's experience of relating has meant a limitation in his or her emotional repertoire. This argues for a

therapeutic approach which seeks to address the consequent deficit in the capacity to relate, without ascribing too much to the child - focusing more on Damasio's (1999) feeling of what happens and less on who feels it, as Alvarez (2012) has taught us. It further necessitates working with the family system. Green (1999:188) has stressed the "crucial factor" of parent work. Seeing children individually without significant parent and family work risks locating the problem in the child, and thereby either confirming the moral system of the family as I risked doing with Clare, and/or perhaps putting the child outside the family system, while they are still dependent upon it; an unhappy and often unsafe place to be.

Furthermore, it is clear that we have to take not just parents but the intergenerational family history into account. Jan Kizilhan (2017), a psychotherapist working with people who have suffered extreme trauma in war, talks about how the emotional pain of family history passes through one generation to the next, so that the individual sitting in front of him as a patient is not alone; he comes with his family and the story of the generations before him. "We don't start with the biography when he is born", he tells us, "we start with the ancestors". Similarly, Gerard Fromm in his book, *Lost in Transmission*, suggests that therapists of apparently treatment resistant patients "consider the nature of the trauma those patients might be carrying from the preceding generation" (2012:113) and advocates taking an interest in the stories of the patient's parents and grandparents, and developing a sense of the social-historical context. This helps give us the missing pieces of the story of who we think we are, wired in from birth, not so much through the *what* as through the *how* of relating: Malloch & Trevarthen's communicative musicality (2010) or Damasio's (1999) feeling of what happens: that's how we come to know the story of who we think we are.

Having started with a poet, I'll end with a physicist who knew a thing or two about relativity:

A human being is part of the whole, called by us, "Universe", a part limited in time and space. He experiences himself, his thoughts and feelings as something separate from the rest, a kind of optical delusion of his consciousness. The striving to free oneself from this delusion is the one issue of true religion. Not to nourish it but to try to overcome it is the way to reach the attainable measure of peace of mind (Einstein, 1950).

References

Alvarez, A. (1992). Live Company: Psychoanalytic Psychotherapy with Autistic, Borderline, Deprived and Abused Children. London: Routledge.

Alvarez, A. (2012). The Thinking Heart: Three levels of psychoanalytic therapy with disturbed children. Routledge.

Armstrong, D. (1992). Names, thoughts and lies: the relevance of Bion's later writing for understanding experiences in groups. In: D. Armstrong & R. French (Eds.) (2005). Organization in the Mind: Psychoanalysis, Group Relations and Organizational Consultancy.

Atzil, S., Hendler, T. & Feldman, R. (2011). Specifying the neurobiological basis of human attachment: Brain, hormones and behavior in synchronous and intrusive mothers. Neuropsychopharmacology, 36(13):2603-15.

Balbernie, R. (2001). Circuits and circumstances: the neurobiological consequences of early relationship experiences and how they shape later behaviour. Journal of Child Psychotherapy, 27(3):237-255.

Balbernie, R. (2002). An infant mental health service. The importance of the early years and evidence-based practice. Available at: <http://understandingchildhood.net/documents/32IMHreport.pdf> Accessed 30.5.17.

Bion, W.R. (1970). Attention and Interpretation. London: Tavistock.

Cozolino, L. (2010). The Neuroscience of Psychotherapy: Healing the Social Brain. NY: Norton.

Damasio, A. (1999). The Feeling of What Happens: Body and Mind in the Making of Consciousness. Florida: Harcourt.

Damasio, A. (2003). Looking for Spinoza: Joy, Sorrow & the Feeling Brain. London: Heinemann.

Donne, J. (1624). Devotions upon emergent occasions and seuerall steps in my sicknes - Meditation XVII. In: Henry Alford, (Ed.) (1839). The Works of John Donne, III:574-5. London: Parker.

Eagleman, D. (2011). Incognito. NY: Random.

Einstein, A. (1950). Letter to Robert Marcus. In: A. Calaprice, (Ed.). (2005). The New Quotable Einstein. NJ: Princeton University.

Emanuel, L. (2002). Deprivation x three: the contribution of organisational dynamics to the 'triple deprivation' of looked after children. Journal of Child Psychotherapy, 28(2):163-179.

Emanuel, L. & Bradley, E. (2008). What Can the Matter Be? Therapeutic Interventions With Parents, Infants, & Young Children. London: Karnac.

Emanuel, R. (2004). Thalamic fear. Journal of Child Psychotherapy, 30: 71-87.

Etkin A., Pittenger, C., Polan, H. J. & Kandel, E. R. (2005). Toward a neurobiology of psychotherapy: basic science and clinical applications. Journal of Neuropsychiatry & Clinical Neuroscience, 17:145–158.

Felitti, V.J et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. American Journal Preventative Medicine, 14(4):245-58.

Ferguson, P. M. (2008). Social capital and children's wellbeing: a critical synthesis of the international social capital literature. International Journal of Social Welfare, 15, 2-18.

Field, T., Healy, B., et al (1988). Infants of depressed mothers show "depressed" behavior even with nondepressed adults. Child Development, 59(6):1569-79.

Fromm, M.G., (2012). Lost in Transmission. London: Karnac.

Gerhardt, S. (2004). Why Love Matters: How affection shapes a baby's brain. Hove: Routledge.

Green, V. (1999). Individual psychoanalytic psychotherapy: assessment, intensive & non-intensive work. In: M. Lanyado & A. Horne (Eds.). The Handbook of Child and Adolescent Psychotherapy: Psychoanalytic Approaches. London: Routledge.

Green, V. (2003). (Ed.). Emotional Development in Psychoanalysis, Attachment Theory and Neuroscience: Creating Connections. Hove: Routledge.

Heijmans, B. et al. (2008). Persistent epigenetic differences associated with prenatal exposure to famine in humans. Proceedings of the National Academy of Sciences, 105(44):17046 –17049.

Hurry, A. (1998): Psychoanalysis and Developmental Therapy. London: Karnac.

Index of Multiple Deprivation, (2015). Available at: <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015>. Accessed on 30.5.17.

Johnston, T. D. (2008). Genes, experience, and behavior. In: Fogel, A., King, B. J. & Shanker, S. G. (Eds.) (2008) Human Development in the Twenty-First Century. Cambridge: Cambridge University:18-24.

Kizilhan, J. (2017). Speaking about his work with Yazidi refugees on Radio 4, 29.5.17. Available online at: <http://www.bbc.co.uk/programmes/b08rp2x0>. Accessed on 30.5.17.

Kolb, B. & Gibb, R. (2011). Brain plasticity and behaviour in the developing brain. Journal of the Canadian Academy of Child and Adolescent Psychiatry, 20(4): 265-276.

LeDoux, J. (2002). Synaptic Self: How Our Brains Become Who We Are. NY: Penguin.

Malloch, S. & Trevarthen, C. (2010). (Eds.) Communicative Musicality: Exploring the basis of human companionship. Oxford:OUP.

McGilchrist, I. (2009). The Master and his Emissary: The Divided Brain and the Making of the Modern World. New Haven: Yale.

Music, G. (2010). Nurturing Natures: Attachment and Children's Emotional, Sociocultural and Brain Development. Hove: Psychology.

Perry, B.D., Pollard, R., Blakely, T., Baker, W. & Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation and “use-dependent” development of the brain: How “states” become “traits”. Infant Mental Health Journal, 16(4), 271-291.

Perry, B.D. & Pollard, R. (1997). Altered brain development following global neglect in early childhood. Proceedings from the Annual Meeting of the Society for Neuroscience, New Orleans.

Pirandello, L. (1921). *Six Characters in Search of an Author*. E. Storer (Trans). (1922). NY: Dutton.

Rejeski W J. & Gauvin, L. (2013). The embodied and relational nature of the mind: implications for clinical interventions in aging individuals and populations. Clinical Interventions in Aging, 8: 657–665.

Rizzolatti, G. & Craighero, L. (2004). The Mirror-Neuron System. Annual Review Neuroscience, 27:169–92.

Brothers, L. (2001). Mistaken Identity: The Mind-Brain Problem Reconsidered. NY: State University.

Rose, S. (2016). On Epigenetics. London Review of Books, 38 (17):15-17

Sander, L. (1975). Infant and Caretaking Environment Investigation and Conceptualization of Adaptive Behavior in a System of Increasing Complexity. In: E. J. Anthony, (Ed.) (1975). Explorations in Child Psychiatry: 129-166. NY: Plenum.

Sandler, J. (1976). Countertransference and Role-Responsiveness. International Review of Psycho-Analysis, 3:43-47.

Schore, A.N. (1994). Affect regulation and the origin of the self: The neurobiology of emotional development. New Jersey: Erlbaum.

Schore, A. N. (2011). The Right Brain Implicit Self Lies at the Core of Psychoanalysis. Psychoanalytic Dialogues, 21:75–100.

Schore, A. N. (2012) The Science of the Art of Psychotherapy. NY: Norton.

Schore, R. (1997). Rethinking the Brain: New Insights into Early Development. NY: Families and Work Institute.

Shonkoff, J. P., & Phillips, D. A. (Eds.) (2000). From Neurons to Neighbourhoods: The Science of Early Childhood Development. National Research Council & Institute of Medicine Committee on Integrating the Science of Early Childhood Development. WDC: National Academy.

Siegel, D. (1999). The developing mind. NY: Guilford.

Siegel, D. (2002). The Neurobiology of 'We': How Relationships, the Mind, and the Brain Interact to Shape Who We Are. Available from the Mindsight Institute & accessed on May 22nd 2017 at:

[https://www.mindsightinstitute.com/system/files/course_downloads/MOL_103 - IPNB and Relationships - The Neurobiology of We_0.pdf](https://www.mindsightinstitute.com/system/files/course_downloads/MOL_103_-_IPNB_and_Relationships_-_The_Neurobiology_of_We_0.pdf)

Siegel, D. (2007). The Mindful Brain. NY: Norton.

Steiner, J. (1993). Psychic Retreats: Pathological Organizations in Psychotic, Neurotic and Borderline Patients. London: Routledge.

Stern, D. (1985). The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology. New York: Basic.

Sutton, S. (2014). Being Taken In: The Framing Relationship. London: Karnac.

Szyf, M. (2009). The early environment and the epigenome. Biochimica et Biophysica Acta, 1790(9): 877-885.

Teicher, M.D. (2000). Wounds that time won't heal: The neurobiology of child abuse. Cerebrum: The Dana Forum on brain science, 2(4): 50-67.

van der Kolk, B. (2014). The Body Keeps the Score: Mind, Brain and Body in the Transformation of Trauma. NY:Viking.

Weitzman et al. (2014). Young child socioemotional/behavioral problems & cumulative psychosocial risk. Infant Mental Health Journal, 35 (1):1-9.

Williams, G. (1997). Internal Landscapes and Foreign Bodies: Eating Disorders and Other Pathologies. London: Karnac.

Myths are Narratives Representative of a Particular Epistemology or Way of Understanding Nature and Organizing Thought. For example, structuralism recognizes paired bundles of opposites (or dualities -- like light and dark) as central to myths. Mythic Narratives often Involve Heroic Characters (possibly proto-humans, super humans, or gods) who mediate inherent, troubling dualities, reconcile us to our realities, or establish the patterns for life as we know it. The more we can understand of the context of a myth, the culture it came from, the individual who told it, when and for what purpose, the audience who received it, etc., the better chance we have of offering an accurate interpretation. Of course, the further back in time one goes, the harder it becomes to study context. Myths are fictional stories that were created to teach a lesson, to explain one of the many mysteries of life as well as phenomenon of nature, and to describe the customs, institutions, or religious rites of a group of people. Examples of myth used in a sentence: I just found out that Icarus flying too close to the sun until his wax wings melted and he crashed into the sea is a myth. I have heard lots of myths in my life. Dialogue: Oscar: I just learned that people speak different languages because they created The Tower of Babel and God didn't want people to unite, so He destroyed the tower. They believe that this common myth is the result of the ivory becoming stained over time, giving the fake teeth the appearance of wood. 5. Women accused of witchcraft were burned at the stake during the Salem Witch Trials. Historians suppose the myth that he was uncommonly small is derived from a series of caricatures of the general by British cartoonist James Gillray in the early 1800s. 16. A penny dropped from the top of the Empire State Building could kill someone. Since most dogs' tongues hang when they pant, many people think that's how canines sweat. But, according to the American Kennel Club, dog's merocrine sweat glands function similarly to humans' and are located on their paw pads. Yes, there are many developing nations in Africa. And yes, most of the myths on this list apply to how people think of Africa. There are developing countries in North America, South America, Asia and Europe. And Africa isn't a monolith of poverty. How much do you think the United States spends in international aid every year? It's probably less than you think. It is important to ask ourselves if we are willing to sacrifice the lives of people who rely on aid until we are sure that every incident of corruption is removed. Of course institutions and governments should be transparent and accountable, but the cost of corruption usually only accounts for a small percentage of total aid.