CELCIS Education Conference 2019 highlights

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I'm going to give a talk, which is largely going to echo a lot of what was just being said, really. I have called it *Shining a Light on the Invisible*, and then with the subtitle: *Adversity, Relationships, and Psychologically Informed Environments* - a very long title. I'm a clinical psychologist, I'm actually employed by the Psychotherapy Department in Edinburgh. It is a small blink and you would miss it psychoanalytic service, which is not very 'in' just now. There's not many of us, it's just four of us. And I don't actually work there I work providing services to people who experience severe and multiple deprivation or multiple exclusion, who are typically homeless, involved in drug services or involved with the criminal justice service. Or typically, all three, I guess the relevance to me of this is there is going to be a report in Scotland coming out in June, which I feel many people are very interested in. I couldn't possibly tell you what's in it. But I can say that it's very likely to say something about the importance of education, in terms of thinking about prevention of the sorts of the outcomes of the people I find myself working with, later on in life. So, the book has a few chapters, just 40. The first one is called the *Invisible Breath*.

I'm going to talk a bit about relationships. I know relationships have been talked about before. I want to stress just how important they are. People have probably read Winnicott (Donald Winnicott, paediatrician and psychoanalyst), if you haven't, you should he's very good. He doesn't get all the sort of plaudits that Bowlby (John Bowlby, psychologist and psychoanalyst) gets because he didn't come up with a theory like attachment theory. But he comes up with stuff like this, 'There's no such thing as a baby', which might come as a surprise, some of you have had babies. And so those of you who haven't had a baby...

He's quite famous. I mean, obviously famous within very small circles of people here. But he's quite famous for coming up with sort of things like this, which don't obviously mean something on the face of it. But what he's talking about here is just how fundamental it is... Those that have babies or remember having them recall that when you get them home, in the car seat, on the table, and you suddenly realise, 'Christ, what we're going to do with this? It is almost entirely useless - it doesn't walk, doesn't talk, can't control its sphincter, can't dress itself...' And you have to start doing stuff with it. And to use Winnicott's sort of 50s language, if you leave it for too long, it will no longer be a going concern. And I guess by that he means it won't be alive. And he means both psychologically, obviously but physically, that actually a child to be a thing in the world that is real and alive, it requires to be in relation to something else. So, in that regard, there's no such thing as a baby on its own, it doesn't exist, it only

exists in as much as it's in relation to something else, be it dad, mum... And I guess the extension of that is that across its lifespan that never really changes. Indeed, for all of us it is only in the degree to which we are in connection and in relation to other people.

That's external relationships, which are a bit easier to describe. I'm going to try and talk about internal relationships because they're quite important, via the medium of Calvin and Hobbes. Calvin is a six-year old boy who loves his pet tiger, not a real tiger, a stuffed tiger, who when there are no adults in the room is sort of alive and real. And in this particular cartoon, he is waking Hobbes up to say that it's bedtime. And Hobbes says I would not have wanted to have slept through that. And Calvin says I wonder why we dream when we sleep? Do our brains just get bored? I wonder why we don't just plain sleep. And Hobbes says I think we dream so we don't have to be apart for so long. If we are in each other's dreams, we can play together all night. And then Calvin says, I'll see you in a few minutes, buddy, and Hobbes says I will be there. And then they are falling asleep so they're moving into unconsciousness, separating from each other. And then in the last panel, they're asleep. So now they're separate. They're no longer in the world with each other. But I guess the idea is that they have each other in their minds. An extension of that would be that our minds, all of our minds are made up of all the external relationships that we've had, that we internalise, and they populate this thing that we ended up calling Adam, or us, or me, or Susan, or Bob, or Calvin, or Hobbes, who has an internal world as well.

The other thing I wanted to talk about here is that things like emotion, and our mental health and our well-being and mental well-being, are very much a consequence of our relational structure. That is our relationships, our internal relationships, that describe our emotional world. Emotions are a consequence of the relational activity that we have internally and externally. So, if you want to know about your mental health, look at your relational network externally. And maybe have a think about the relationships we have internally.

Does anyone feel they have an internal world? Exciting, isn't it? No-one can see it, you can do what you like. The important thing that I think about it is not to over-egg it. But to sort of say that relationships are a bit like the psychological equivalent of breathing. And breathing is something that we have been doing since we were born, and to the point where we've become very skilled at it. And we don't really notice it. We just sort of take it for granted, really, until it starts going wrong. And those who've ever choked or seen anyone choke, will realise that it's horrible. And it's at that point, you start to understand something very fundamental about breathing, which is it's the whole shooting match. And if you're not breathing, it's all over, it's finished, you don't have to worry about your mortgage or anything else that's going on, because you're going to die very, very soon.

And relationships will be like that. They are something that we do automatically and invisibly. If they're going well, we don't notice them. We don't tend to come home at the end of the day and say: ‘Yes, I managed to sustain a number of emotionally and psychologically satisfying relationships with another successful

day.’ But we do notice, I guess, if they choke, even those with relatively healthy relational worlds will notice when something goes wrong - if someone dies or a friend says they don't like us anymore, or something goes wrong in our relationships, and we choke a bit and we feel there's a sort of an emotional response.

A lot of the people I work with, by virtue of the sorts of experiences they've had, typically, their relationships, choke a lot. And it's one way of understanding things like homelessness and substance misuse and mental health problems, and being involved in the criminal justice system is that they are very late emerging symptoms of some very, very early relational difficulties. But if have difficulties in forming and maintaining life-giving relationships in the world, then the consequences are severe, extremely severe and extremely life-limiting to the point where one of the logical endpoints might be you are homeless, relationshipless, jobless, disconnected - very, very disconnected. Which brings an interesting irony to the term independence in the health service. We're big on independence, we like people to be independent. So, who the hell is independent? None of us are independent. In fact, I am very proud of my dependency, my dependency keeps me alive. If you want to see someone who's really independent, see some of the people I'm involved with. They are as close to an independent human being as can be - they really can't make healthy dependent connections in some way. Well, you can watch Castaway with Tom Hanks, but even he sort of gets quite attached to a volleyball.

That was chapter one.

Chapter two: ‘*Those who cannot remember the past are condemned to repeat it’* (George Santayani). I want to talk a bit about some of the consequences of adversity and how that impacts on relationships. In my experience, most adversity, trauma, neglect or deprivation tends to happen within the relational world. In fact, everything happens in the relational world so, of course, it is affected by relationships. People will probably be very familiar with this quote - familiar with Thing One and Thing Two. I quite like it.

What I quite like about the term adversity is it's very, very broad. And certainly in terms of the people I find myself in relation to, the sorts of adversity, their experiences are very, very broad. Some very, very obvious, like trauma, abuse and neglect. Some are less obvious, like being sent to a private school when you're eight and becoming disconnected from your mom in a way that you find very, very traumatic. But even later on you tell your psychiatrist that you had a normal childhood. And it's not immediately obvious as something that might be traumatic to somebody. But I think there's something in our early years about choice. That you start to think about whether any of us really chose our minds, whether we chose our experience, whether we chose our parents. I don't suppose anyone in this room did choose their minds did they? Chose who they were? Similarly, has anyone here ever tried to change their mind? I don't mean give up smoking, or go to the gym, I mean stop being you and be someone else? It's a hard thing to do, and often in the health service, you are asking people to stop being them and be someone else, and wondering why they are deeply resistant to that particular sort of activity. We use terms like choice and

say he's making choices. He's making choices to burgle this house or beat this person up or take drugs, whatever it might be - like, in some way, we have choices about this sort of thing - trauma and adversity in terms of our experience. And going back to talk about the Calvin and Hobbes, this is something we tend to internalise and it starts to make up who populates our internal world about who we are and how we understand the world, and how we understand relationships in it.

That can lead to some very complicated and interesting responses, particularly to things like care. I work for the health service, we're very pathological about care, we make hospitals and say, 'We're going to help you, we're going to care for you.' And we tend to get very, very bent out of shape when we find ourselves in relation to people who don't do care properly, who do things like say they really, really want to care, and then later on, say, they really don't want to care. And who sometimes do that in sort of one sentence. We really don't like that we quite like people who come along and do care properly, who say 'I really want care' and we give them care and they say 'Thanks very much, your care is really good.' And they digest that and they get better and give us a box of chocolates and a thank you card. We like that sort of stuff, it's really nice. That's the way the health service should work. But of course, if people whose experiences of care have been very problematic and what they've learned is that actually care might be something that you shouldn't trust, or it might be something that's at least complicated by an idea that something difficult might happen, then you might find that you have competing relationships in your mind - sort of ambivalence where there may be a part of you that is very, very interested, in fact, very, very starving and hungry for care, and another part that is deeply phobic of the idea that anybody would ever get attached to you, or help you or care for you at all in any sort of way. This can lead to all sorts of interesting misunderstandings. Here is Winnicott again, his famous quote: 'When a young person is to be found running down the street smashing windows, he's looking for his mother.'

That's quite hard sell that in the High Court. What he's talking about, what he's trying to say is that if somebody has not been able to find something solid and reliable and containing and robust - the kind of ideas of what good quality relationships might look like - then he may go and look for it elsewhere, he may go and start looking for containment or looking for boundaries or looking for something outside of the home. But interestingly, if he's expressing his distress in distressing ways then he may not evoke concern, like when someone is smashing your window. It doesn't tend to be the case of you saying 'poor chap, he looks really lost. I wonder what this behaviour means' - that doesn't tend to be our initial response when someone's breaking into our house or doing things that can evoke responses that, interestingly, sometimes replicate the very thing that's driven the behaviour - that sometimes people can behave in ways to evoke quite abusive responses in us even though it may be the case that this person has come from a very abusive background.

The relationships are still there. These are still relationships. This is a very definite relationship. This person is kicking this window in, he is the Joker. Anyone seen this film? Here's the Joker in the Batman films and he's involved in the business just now in this film of blowing up the hospital. So that's not a benign relationship, but it is a really strong relationship. He's blowing it up, he has a very interesting and powerful and definite relationship with the hospital. He doesn't like it, and he's gone out of his way to buy explosives, and then take the time to rig it all up and blow the thing up. It's a very interesting thing to do. He's not just walking past it, benign. And this is the sort of person Hinshelwood (Robert Hinshelwood, psychiatrist and academic) is talking about. He is a psychoanalyst who used to try and work with the health service to get them to be a bit more thoughtful about what they do, with some success. And here he is trying to talk to psychiatrists about a group of people who attracted the term, the diagnosis, of personality disorder. They have relationships with carers that are characteristic, and sometimes they're characterised by the defeat of health. And they say something about the defeat of health in health care workers, which can be quite problematic, and lead us to do what psychologists would call enactment, where we end up replicating the very thing that might have brought the person to see us in the first place. So, you may have somebody, for example, who's had a fair amount of intrusive sexual trauma and they express it in a range of distressing ways. And then we find ourselves locking them up in hospital and sticking needles into them, in a way that almost completely re-enacts some of the trauma that has brought them to that hospital in the first place. But it's done under the guise of treatment, we are treating but without any real thought about what the relational dynamic might be doing. Or what it might be re-enacting in terms of playing out the traumatic dynamic that's been brought into the care service as well.

This is from a paper called The Ailment by Thomas Main (Thomas Main, physician, psychiatrist, and psychoanalyst), which says that: 'Patients who frustrate therapists by failing to improve are always in danger of meeting primitive human behaviour disguised as treatment.'

And I guess you could see that in places like education, where the child frustrates the teacher, by failing to learn and is always in danger of meeting some kind of primitive human behaviour disguised as, I don't know - behaviour management, maybe might be the term - I'm not particularly sure. But that's not to be critical, really. I think there's something very, very important to think about and connected in terms of when people who have experienced very, very high levels of trauma, adversity and distress, express that distress in very distressing ways. It's very ordinary for us to respond in ways that re-enact that. You'll be familiar with these very popular sort of headlines, certainly. But it's a very easy to split isn't it, to think there is somebody good, and there's somebody bad, and it has a sort of cognitive simplicity to it and satisfies perhaps our own emotional responses to what has gone on. People, I'm sure remember these images from Baby P. And it was interesting hearing reasonably thoughtful media outlets find themselves in the real language of abuse, that something very abusive has happened here and what we should do is abuse these people, because they've done something, or we should abuse the social worker. It felt

very hard to get out of the abusive dynamic, because there's something that had gone on which evokes very, very strong emotional responses in us. And I'm not being critical of that, I think you have to acknowledge that there is sometimes things that happen that can evoke very strong responses. But how do you think about it? Because I guess the inconvenient truth is these people here were once the age of Baby P. And also, this child, Baby P, made the news because he died, and of course the vast majority of baby Ps don't die. And they don't make it into the news. And they're not a big national story. They live and they become six and they become eight, they become ten. And it's not that it's a definite life course. But what sort of things might this person be doing when they are 14 or 16? At what point does our sympathy move from 'that's terrible' to 'what wee shite, what is he doing that for?' Or something more extreme actually, when this child is expressing some of their early distress in very, very distressing ways to other people? How do we understand that, how do we remain thoughtful in the face of that?

That was chapter two. That was the difficult chapter.

Chapter three: *Under the Bonnet*. 'Three fish in a tree. Fish in a tree? How can that be?' So, under the bonnet. How do you really get into thinking about what a relationship is? Here's a picture of a young boy surfing. I don't know who this is. But my son did go to a surfing lesson. We live in in Haddington and he went to a surfing lesson in Dunbar. I took him along and dropped him off and sat around, came back after about two hours, and picked him up and asked him how was the surfing? And it was really quite insightful. All he told me about was content, only content, he said, 'we went down to the beach and then we got the wetsuit, and we were standing and it was a bit scratchy, then we went to the sea and the waves came over the top of us and it was cold with the wind... And the punchline was: and at some point, we stood up and I was surfing, I'm really good.'

It was all content.

What he didn't say at any point was, 'You dropped me at the car park. And because of the relational history that you and I have, from what I've internalised, I was able to go with this man who I've never met before. And take onboard some of the stuff that he said, I was able to internalise it, digest it and make use of it. So, when he gave me instructions to come follow him into the sea, a place of relative danger, I was happy to go along. Because of my internal world, that's been populated by the experiences I've had with you and with other people and the rest of it. And I don't really have a model in my mind for man who's going to take me into the sea and drown me. As a consequence of all of that, I was able to learn to surf,' but he didn't even mention it.

But of course, the reality of that is the only reason he learned anything, was because he had come along. And if what all he really knew was that you do not trust strange men, for example, or you just do not trust adults, because they might abuse you or harm you, and the instructor said come on let's go down to the beach, my son might have said 'I am not going with you, you weirdo' and something else might have happened, like he might have been sent out to the dunes and he could really explore the business being excluded and separate and

not understood, not belonging. And he could have done that for two hours in a way that he could keep his own version of the world alive in some ways. That's what I mean about the invisibility of it. There's something about relational dynamics that is very, very hard to see. They are there and we can feel them sometimes. But they're not obvious.

In a healthcare service, we can be at times institutionally autistic about this. And what I mean is, as individuals we have our minds, and we're pretty pathological about healthcare, which is why we end up becoming a doctor. Of course, you don't become a doctor or a psychologist by accident. There is a slightly pathological commitment to the business of helping, or doing something or sorting something out. And so, we have our minds. And then typically, health services are designed by the healthy. Drug services are designed by people who don't take drugs, and homeless services are designed by the housed. And so, we have our minds, and we don't understand, necessarily that other people have other minds.

So, we built the health service with a very, very fundamental premise in with the bricks and the foundations that we rarely articulate. In fact, we never articulate it, but it's utterly key. And that is the health service requires you to be able to come along and trust somebody who says they are going to help you. That's how the whole thing runs, it is not articulated, but that's what it's requiring you to do. You go to the clinic, to sit in the waiting room, and to go into a room with a stranger and door shut behind you, all that sort of stuff. And when people don't do that, that is what I mean by not doing healthcare properly, and we tend to exclude them by doing things like discharging them, or banning them, or calling them personality disorders, or whatever it might be as a way of not having to be in relation to them. And there is something about the ways in which they're relating to us, which defeat us, and we can start excluding them in some way. We do that even in Trauma Services. Ironically, we will do things like discharge people, if they miss three appointments. And you would think that in Trauma Services, we would understand that actually, some people might be very, very ambivalent and understandably anxious about what it might mean to come along and be in relation to someone, go into the room with them and have them ask you questions and stuff and get inside you, and be interested in all that sort of ways. But we don't need to exclude them or discharge them. Similarly, we discharge lots and lots of people from the mental health service because they are not engaging or interacting with us 'properly'. Usually what we're discharging there is the feelings that they evoke in us - that there's something about the way in which they're relating, which annoys us, defeats us, pisses us off. We feel deprived, maybe we feel abused, maybe we feel neglected. And by God, we didn't train for 11 years, to be made to feel useless in this sort of way. So, we can solve that problem by discharging the patient and getting rid of them. And in the same way, getting rid of the feelings that they're evoking - or locking them up. Or calling them nice, friendly terms like personality disorder - you can bet your ass that wasn't a term made up by a patient. That's one group of people talking about how they feel about another group of people, and what they are doing and how they're relating to them.

I assume the same as similar in education. This is my school, there's lots of content, it's all about content. When you hear about school on the News it tends to be about content. Interestingly, with the people I work with, if there's one thing they could have learned at school - just one - it would have been that you can trust a human being - at least one human being. That would have been a great outcome. Because I work with people who can still learn educational content, about History, and Geography, and Maths and English and all that sort of stuff, which is important. But try teaching a 40 year old man trust. It is very, very, very hard at that age in my experience. It strikes me that for some kids who come into school, what they have learned, even by the time they get into school is, be very, very wary of adults, don't trust them. That can be a huge barrier to learning, like in a surf lesson. If you're coming along, and you're spending most of your time monitoring the person who's teaching you and wondering whether they're going to harm you, or do something to you, that can really, really get in the way of learning. And it doesn't matter how many whiteboards you have, or iPads. That's not the issue here. It's about all education is relational. It's a relationship between a group of people called teachers and a group of people called pupils, for example, but the fundamental conduit, like with the health service is the relational contact between those two people. If that's problematic in any way, then learning is going to be compromised.

Similarly, targets. These targets are of interest, because again, built into them is an assumption that somebody can do the business of being in relation to somebody who's teaching them. There's nothing in here, which says, 'Look, just before we go to the target, is the relational basis in place, have you even looked at it, have you thought about whether this person is able to make a human connection that would allow learning to happen?' Because kids, when they're in very, very secure attachments, we can't stop them learning. And when it is all going well, it sort of looks great, doesn't it? Because, when the car is nice and shiny, and it is doing well, and things are running very, very smoothly. We don't tend to look under the bonnet, really, because it's a bit messy under there and we don't really know how it works. But when it is going wrong, I think it's incredibly important to start by looking at the more invisible stuff, this sort of relational context in which things like learning and health and care happen. That requires looking under the bonnet of the people we are working with. But, fundamentally as well, we are also required to look under our own bonnet. What are we learning? How are we setting ourselves up? What are our desires? What are our motives?

Again, I think in the health service we are very good at talking about patients. 'Let's talk about a patient, Yes, let's talk about a patient.' And we spend 99.5% of the time talking about patients, and very little time thinking about, What are we up to? How have we set these services up? What does it mean? How do we set ourselves up in relation to the group of people that we're working with? What does discharging someone after 3 missed appointments mean? Why would we do that? How does it make sense?

We don't spend a huge amount of time doing that. So, as I say we can be slightly autistic about the way care should happen. It's like this John Lewis transaction of, 'I need a kettle - good.' 'We have a kettle.' 'Good, take the money and everyone is happy.' That's kind of the way we'd like the health service to view someone. But that is not always going to work and you have to work very, very hard, I think to get services to be thoughtful about how people are relating to that service, particularly when people are relating in ways that can evoke difficult feelings in the carer - that as carers or teachers, you can end up feeling defeated, hated, abused, neglected. All of those sorts of traumatic dynamics that might be coming from somebody's history.

It's far easier to sort of shift our attention to Mrs. Brown, who turns up and fills in all her thought diaries and gets better and I feel this is great - this is where I feel like a really good psychologist, she's getting better. Everyone's a winner. It's great. Compared to Mr. Brown, here, he just comes along every week to tell me how utterly useless I am and how he's not getting any better. You'd have to be a masochist to want to spend your time in relation to them. Actually, this might be the person with the greater health need, but interestingly, in healthcare we have a sort of version of the attainment gap called the inverse care law, which means the people who need the least tend to get the most, and those who need the most care to get the least. And one of the things that underpins it is the emotional world that sits underneath the care relationship. And then we might find ourselves unconsciously, and at times consciously drifting towards giving more care to people who do care properly, and shifting those resources away from people who don't do care properly, and locating the problem in them and saying, it's because they're not doing care properly. If they just changed their minds to do care properly, then we could all be happy about it.

And I guess it's similar with the attainment gap. So you might find, unconsciously, that it might be easier to spend your time and resources with a pupil who has a big appetite for learning and can engage with you and make you feel good as a teacher – 'I'm doing well, trained to be a teacher and look, this child is learning!' That might be a far more attractive proposition to being in relation to somebody where you think 'I've done nothing, I've achieved nothing, content wise, nothing concrete'. But you may have achieved something just by staying in relation to them. And again, that's always been a very hard sell with the health service to say that there might be an outcome, which is just about staying in a relationship with people past the point where everyone else says, 'Sorry, I've had enough'.

That was chapter three.

This is the last chapter: '*There is a light and it never goes out'* Morrissey. Morrissey has some interesting views now, but he was a good lyricist in his time. This is not supposed to be pessimistic, far from it. And from what we know from psychotherapy research studies, interestingly, we tend to like this sort of data, is that it's not really the technical stuff that you do with somebody in a room that really describes the outcome. It's the quality and the nature of the attachment. And the quality of the relationship is the biggest predictor of outcome by a mile, whether you're doing CBT (Cognitive behavioural therapy), DBT (Dialectical

behaviour therapy), or whatever... It's actually the bit that's underneath it, that seems to actually predict outcome with the quality and the nature of the relationship, and my understanding of the educational process, is that it is a very similar system. There might be something about the way in which the relationship of education goes, and starts to actually describe the outcome of that process in someone. So, the answer to looking at psychologically informed environments as a way of understanding an approach, to working with more difficult situations...

So has anyone seen one of these before? Yes, but in our house we call it the Mind Gym because we are middle class. But I think it may also call it this on the box, the Mind Gym. The point is about this. It's an environment that has not just been randomly arrived at, but this is drawn upon an evidence base about what makes babies' cortexes tick, and so, you get lots of black and white themes. Pandas have made a huge comeback from the toy wilderness. The pandas are big, because they're black and white and we have found that babies really like high contrast stuff. So, in an ideal world, this whole thing would be black and white, but then parents wouldn't buy it. So, you have to come up with some kind of compromise which is a bit of like a black and white, like the black and white trim around the edge. And then babies also really like faces like this configuration, and pandas are like catnip for babies because they've got the whole face thing going on. And they've got the whole black and white thing going on. That's all a psychologically informed environment really means. It means can we inform what we do, based on a sound, evidence based understanding of what the psychological and emotional needs are of the people we are working with. That's all. I like the generality, that it's not getting into 'trauma informed'... Psychologists are very good at narrowing definitions and by doing so, excluding, as opposed to keeping it really nice and broad. Let's just be informed and have a good and understanding of what's going on. And that might describe it well.

So, to give you a couple of case examples. One is a word and it's this word, ENGAGEMENT. And, again, in the health service, we use this word a lot, typically in the context of this person's not engaging. 'Yes, I know, Bob, he really needs to engage'.

But what we really mean by engagement is this. We like it when people do things like turn up and get involved in the business of doing treatment. And get better, say 'thank you', and all the rest of it. We don't like it so much when somebody ignores us. But to me, it's all engagement, you know, often when we're talking about someone not engaging, because maybe 15 of us sat around the table saying, 'Bob really isn't engaging', I think, when's the last time 15 people sat around the table talking about me? Bob really is engaging, like he's pissed us off. And that's interesting engagement. If we go back to the under the bonnet stuff, and spend some time thinking about how we feel about the engagement that we are having, it is definitely engagement, because we are feeling it, we're all irritated, we're all annoyed, frustrated, or whatever it might be. That might be useful. Maybe we should think about that and pay some

attention to it, rather than just locating it in Bob, and saying Bob's the problem isn't he? Because he's not doing it properly.

So, in this slide, here we have someone doing therapy. This is great. We like this. And here's Bob at an appointment with me half an hour ago, and he's engaging by not turning up. That's his engagement, maybe he's trying to teach me something about being abandoned, or what it means to be left, or maybe showing me something about disappointment, or about not mattering or something, maybe there's something in the not turning up, which is really important if I spent some time sort of thinking about it in some way.

Because we really struggle with that sort of engagement, we have a very monolithic idea of what engagement is, and it is: turn up, do the stuff, go home. Say thank you. So I guess the idea is, it's all engagement. You can think about somebody, you're in a relationship with, of one type or another. And we might usefully spend a bit of time thinking about the quality and the nature of that of that relationship, particularly when some of the feelings that are evoked in us are difficult or troubling, anxiety provoking, worrying, less perhaps important when it's all running very, very smoothly.

So, I'm going to give you case example, a real one this time. of somebody I been involved in working with for a number of years, who has multiple complex needs. We don't really know what it means, but I can say bit more about it in a minute. She's a young female that lives in supported accommodation. She's dependent on her carers for the basic activities of daily living, and she splits carers. By that I mean she can sort of get very involved with some members of staff and sort of, ‘Oh, you're very good, you understand me better than anyone else’. And then the reverse with others. She engages the support in a variety of interesting ways, and can be very demanding. Sometimes 'I need this, I need this!' And other times, 'I don't need anybody!' - that sort of quite complicated relationship. She's very, very emotionally labile and by that I mean ranging from extremes of happiness, to floods of tears, often in a very, very short space of time. She is very occasionally aggressive and can be violent. This is important, as I've been talking about it, she can evoke strong extremes of emotion in her carers, which can range from wanting to do anything for her, love her and look after her forever, to just like 'See ya! I never ever want to see you again’. She gets called bonkers by other residents, and she has a range of dependencies and addictions, and some very volatile relationships with a friend. I've been involved with her for a number of years. And I asked if I could show a picture of her. And she said yes.

Here she is, my daughter, she's six, and all of this is true about her, and she gets away with it, because she's six. But if she's pulling this shit when she was 35, she'd attract the diagnosis of borderline personality disorder quite easily. She is in treatment programme with me and Claire, and we're not doing anything particularly fancy - it doesn't really help that I'm a psychologist, frankly - we are doing a sort of muddling through like most people do, and try to be consistent and reliable and bear it all. It helps that we're psychotically in love with her, because if we weren't, then it might be more difficult, but it's worth it. It just highlights that we all have multiple and complex needs, all of us. And sometimes

they're not so noticeable because they're being met, and we have a good capacity to get them met. And they're not particularly obvious in some way. But when we can't get them met, they become obvious. And I guess the idea here is that Iris will just grow out of this. But we don't grow out of anything - we develop out of things depending on the quality and the nature of the relationships that we are in developmentally. And they will describe the degree to which we end up with a mind that is populated in the variety of ways that we have talked about.

It is worth remembering, for example, there is a worldwide multi-centre trial going on at any one point in time, that deals with education, health, social care, justice, and all the rest of it and it is called the family. And most patients come out of the family doing okay, actually. It's interesting, when we come to develop things like mental health services, we just ditch the family, we forget all of that. And we do something completely different, that doesn't really pay attention to what are the fundamental health giving properties of the family, which we know quite a lot about. And they are things like stability, reliability, containment, dependability, trust, tolerance, bearing stuff, being consistent. Not saying 'well that's the toddler parents off, you'll meet the new parents in a week, they'll take you through to 13, and then the adolescent parents will come in, and they will deal with the tricky stuff.' And it's hard work. We've all been there. It's hard to bear and to contain and to tolerate, sometimes emotionally. That can be very, very challenging, and very, very difficult. It's extra work. And it's difficult work. Sometimes I get annoyed when people, like myself, go around telling people that 'You need to be trauma informed. And you need to do this and be more compassionate', like it's no extra work. But you're busy enough as it is without really having to acknowledge that sometimes it's very, very hard to stay interested and curious and thoughtful about someone who seems to be working really hard to kill off your interest and evoke very strong feelings and things like hatred and dislike.

We get memos saying you must really like all your patients and be compassionate. What about the ones you hate? It's really important to acknowledge things like hatred, because if you don't, it's far more likely that you will enact it in some way that might be problematic. And keep on doing the very thing that has evoked hatred in the first place. You should have some sort of process where you can think about hate usefully and try and use it to understand how we might position ourselves in relation to that person, rather than just saying, let's get rid of them in some way.

This is the end. As we've talked about, education is fundamentally relational. And that affects many of the kids who may end up coming into contact with me later on. Trust - something so basic, so simple that we take it for granted. Like breathing, unless we don't have it is utterly, utterly fundamental. How do you teach that it's not an intellectual property. You can't write it on a blackboard. It only develops in relationships. It is transactional it's developmental it comes with time and experience. And as it says in the hard edges report, people say something very fundamental about how important education might be to teach

people not just things about content, but something about what it is to exist in the world as a relational human being.

As I say, that is extra work, I think it really is extra work. Most of my time is spent going around supporting staff. I have about 25 staff groups who work with people in the homeless sector in and around Edinburgh and the Lothians. And it's a chance for them to come and talk about hatred, and talk about frustration, talk about defeat, and talk about all sorts of feelings that are very genuine and very real. And if we didn't pay attention to them, it would make it far more likely that that worker is going to discharge that person, who we know has experienced some of our highest levels of social injustice going. We know that, we can read it, we know about their history, but it doesn't stop us at times having some complicated feelings about them that don't necessarily organise us towards being caring. So you need to put things in place to think about that sort of stuff and take that side of it very seriously.

So, the title is to *Shine a Light on this Invisible Stuff* that is either taboo, because the organisation says ' You mustn't hate people, that's terrible, you must like them all.'

Well, that doesn't get us anywhere, we need to pay attention to the things that are actually going on, and try to do something useful with them. And it's really clear, isn't it, when there's falling masonry all over the place, you might have to find a hardhat for your protection. But who has ever seen one of these signs for psychological safety at their place of work? What if you had a sign that said: no supervision, no protected reflective practice, no dedicated time for training and support: No Entry. By not doing this, you're not seeing any kids, unless you have all this protection in place, it makes it very easy to see I guess in bricks or flying around. But actually, in a lot of the places we work there is a lot of psychological masonary flying around, but it's invisible. You don't see it, you feel it. And it gives rise to things like burnout, and all sorts of stuff, and punitive responses to people and all sorts of things. So how do you take this sort of stuff and shine a light on it and recognise it and then put things in place for it. I think professions like mine have a responsibility.

John Swinney was talking about integration, I think that's really, really important. This is usually what the psychology service looks like, it's sort of here, one person can come up at a time, to come and see a specialist up in the tower for treatment, and then sort of climb back down again. Whereas in many cases, I think a lot of our time and resource might be better spent supporting the people who do all of the work, you see lots of people in schools or support workers or GPs, or places where there's large contact with large portions of the population, take a more general public health approach to this sort of thing. Rather than, 'Oh, that individual there, that child there, he's got a problem in him, he needs to go up the tower to go and see the specialist. And then when he's had the treatment, he can come back down and join the rest of the people.' And it's not really much connection between the two, I suppose we're all in the mental health business, all of us, I don't think studying to be a clinical psychologist, or psychoanalyst for that matter, necessarily makes me a better person in terms of being in relation to people, I just don't buy it. I don't think

that's true. I think there's huge amounts of the workforce that have a huge and great capacity to be therapeutic to the people they're working with. And I think services like mine could do well to distribute some of our resources more broadly, across all sorts of other services such that we really did have something a bit more integrated.

Thanks very much.