NEWSLETTER

FACULTY OF MEDICAL PSYCHOTHERAPY

Autumn/Winter 2022

In this edition

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Editor's Welcome

Pamela Peters

Consultant Psychiatrist in Medical Psychotherapy, Cambridge and Peterborough Foundation Trust

Hello to you all and welcome to the Autumn edition of the newsletter. Autumn is a time of dramatic change as the temperatures cool, the light slowly fades, and the colours have a burst of vibrancy before everything goes dormant for winter. So too are dramatic changes happening in the world around us – political and economic upheaval and the anxieties of winter ahead and tough times to come for so many. Never before has it felt so imperative that we stay connected to each other and to a sense of community in order to survive and to thrive.

The Medical Psychotherapy Faculty Exec has an energy and momentum that is apparent in the numerous working groups, events and conferences you will read about in this edition. It has felt inspiring to be part of in-person events again, to feel part of a group and movement that is active and alive, influencing the College as well as individual Trusts around the country. The recent conference on the Effect of Patient Homicide on Clinicians was a ground-breaking event – opening up hitherto difficult and hidden conversations. This event was organised by Rachel Gibbons and others from the Royal College of Psychiatrists' Working Group on the Effect of Suicide and Homicide on Clinicians with the aim of changing the culture around these events to be more understanding, compassionate and supportive of clinicians. There are also recently-released new curricula for training which have taken years of painstaking work by the SAC, described further in the SAC Chair's report below.

As ever, I am grateful to all those who have submitted articles for publication. For various reasons, not every article can be published, but please continue to write and to send in your contributions.

Message from the Faculty Chair

Jo O'Reilly

Consultant Psychiatrist in Medical Psychotherapy, Camden & Islington NHS Foundation Trust

Hello and a warm welcome to the Autumn edition of the Medical Psychotherapy Faculty newsletter. I am very grateful to Pamela Peters and her editorial team for their hard work, and to all the contributors for providing us with so many such rich and varied articles to learn from, be stimulated by and to enjoy.

I am aware there are many challenges facing us as a society currently which impact powerfully on our lives both at work and at home. As the impact of the covid pandemic has receded over the summer months the siren-call warnings of the devastating impact of climate change intensify, with the heatwaves and drought in the UK and wider evidence of extreme weather and its deadly consequences globally. The cost of over-consumption and the power of denial as a psychological defence are powerfully in play as we continue to damage the habitat and natural world upon which we depend. The war in Ukraine, energy and cost of living crises add to the likelihood of an extremely challenging winter ahead. In our workplaces the impact of all these factors on the mental health of our patients, our colleagues and ourselves is all too evident and workforce recruitment and retention issues mean many services and clinical teams are struggling with the pressure of their working lives. The need to support each other, to mourn the losses we are facing, to adapt, and to change our habits and expectations are urgent priorities given the scale of these challenges.

On a brighter note the Medical Psychotherapy Faculty Executive Committee met in person at the RCPsych for the first time in over 2 years in June. It was heartening to see the pleasure in the room and how this acted as a stimulus to creativity as we reconnected with each other as a working group and welcomed new members. We took the opportunity to re-consider the primary task of the Committee, to review our ongoing workstreams and develop ideas about our priorities looking to the future. Strengthening our voice as a Faculty and articulating the importance of psychological thinking within psychiatry, tackling inequities in service provision and active promotion of staff support, including through high quality reflective practice, are central to our activities and there is much work to be done. Members of the Faculty played a central role in facilitating a workforce wellbeing event for colleagues in NHS leadership roles, jointly hosted by the RCPsych and Drs in Distress in May 2022 and this led to an open letter to Chris Whitty and Amanda Pritchard, Chief Executive of NHS England, stating the importance of supporting NHS staff with the emotional impact of the work, signed by colleagues across medicine and in NHS leadership roles. This event highlighted to me the value of the contributions medical psychotherapists can make at a national level to the challenges we are facing as a workforce, in addition to the work many of us already do within our own organisations.

I am delighted that we had several volunteers for the role of Academic secretary and that there will be a Medical psychotherapy Faculty conference in April 2023, having been unable to host one in 2022. Other events I would like to draw your attention to include the Impact of Homicide upon Clinicians, organised by Rachel Gibbons on 18th October 2022 and the next psychodynamic psychiatry day on 11th November 2022 looking at psychodynamic aspects of working therapeutically with psychedelics and the potential new treatments which are emerging.

Message from the Academic Secretaries

Sophie Atwood
Consultant Psychiatrist in Medical Psychotherapy, Sussex

Parveen Bains
Consultant Psychiatrist in Medical Psychotherapy, Hertfordshire

Vikram Luthra
Consultant Psychiatrist in Medical Psychotherapy and Psychoanalyst, Leeds

Anne Cooper
Consultant Psychiatrist in Medical Psychotherapy, Leeds

First off, we wanted to introduce ourselves as the new Academic Secretaries going forward. Yes, there are four of us, we have decided to share the role, given it is a fairly large and complex one, and thinking four heads is better than one. This also means that we can pool our experiences for the Medical Psychotherapy Faculty conference planning and ensure we have an exciting and inclusive event!

We have agreed that each year one of us will take the overall lead, but that we will share out the various tasks between us.

Sophie Atwood: I'm a Consultant Psychiatrist in Medical Psychotherapy and Psychotherapy Tutor based in Sussex, and am Regional Representative for Kent, Surrey and Sussex. I aim to foster opportunities for psychiatrists across their careers to practice and develop psychotherapeutically, as well as promoting psychotherapeutically minded medicine in medical school, general practice and all specialties. Linked to this is my interest in mind-body issues - working with patients whose presentation crosses over between physical and mental health services.

Parveen Bains: I am a Consultant Psychiatrist in Medical Psychotherapy and Psychotherapy tutor based in Hertfordshire and Regional Representative for the East of England region. My interests include working with trainees of all grades, and I have a clinical interest in psychotherapy with clients with Eating Disorders.

Vikram Luthra: I am a Consultant Psychiatrist in Medical Psychotherapy and Psychoanalyst, based in Leeds. I am the Regional Representative for the Yorkshire and Humber region. I am passionate about Balint groups and introducing psychoanalytic thinking to postgraduate doctors in training. I am also the clinical lead for the doctors and dentists in difficulty service (Take Time) across the Yorkshire and Humber region. I look forward to working with my colleagues in the academic secretary role to showcase all the talent within the best Faculty in the college!

Anne Cooper: I am a Medical Psychotherapist based in Leeds like Vikram, but specialising in CBT, and looking forward to working alongside my colleagues and helping fly the flag for CBT, ensuring that psychotherapy refers to all modalities of delivery. I am also passionate about teaching and training, especially amongst undergraduates, addressing stigma and being inclusive!

Going forward, we are excited to announce the dates of the next in person **Medical Psychotherapy Faculty Annual Conference, April 17th – 19th** inclusive, entitled **"Can the current global crisis bring us all together?"**. We are excited to be holding this conference in person at the College and catching up with friends and colleagues from the UK and further afield! This conference will see us announce the 2nd winner of our annual Medical Student essay prize which was launched last year, as well as the usual trainee poster prize. The details of both of these prizes are on the College website. Please save the date!

We are looking forward to the forthcoming **Psychodynamic Psychiatry day** taking place on **11th November** this year which is on the fascinating topic of Psychodynamic aspects of psychedelic assisted therapy. This is taking place in person at the College but will also be live streamed and should prove to be a stimulating and informative day.

We will also be working with trainees and the Chair of the Regional Representatives to develop the medical student area on the Medical Psychotherapy Faculty website.

We are delighted to have our own Medical Psychotherapy Faculty Psychiatry Star, Jessica Sinyor, who had a particularly strong application. The Psychiatry Star Scheme is the scheme which provides mentoring and sponsorship for a medical student interested in a career in psychiatry. Congratulations to Jessica! We look forward to getting to know Jessica over the coming year.

Message from the Chair of the Specialty Advisory Committee

William Burbridge-James
Consultant Psychiatrist in Medical Psychotherapy, Essex Partnership University NHS

It is the return of autumn and time for me to reflect on the last eight years that I have been privileged to be the FEC (Faculty Education and Curriculum Committee) Chair, which then became the SAC (Specialty Advisory Committee). The term of office is usually 4 years, but the circumstances of the curricula re-write combined with the hiatus of the pandemic led to my term being extended to accommodate the work. Now, as the phase of curriculum work reaches a culmination, the role needs a fresh pair of hands to bring new energy, ideas, and commitment to maintain the structure and importance of psychotherapy training in the development of psychiatry as a whole, as well as for speciality training in Medical Psychotherapy.

As with much that has become electronic like our patient records – history and development can be hard to trace, and I think it is helpful for the Faculty readership to have some context to the developments that now are part of the fabric of training. I came into the role having been on the FECC when my predecessor James Johnston was chair, James having taken over from Chess Denman. Chess and James had made progressive changes to strengthen the curriculum and the position of psychotherapy training in psychiatry. Chess had developed the position and role of a 'Psychotherapy tutor' who would have educational governance for the delivery and quality of psychotherapy training for trainees, where this role had not been formalised before, and had this incorporated into the core curriculum. Chess and the FECC at the time had also developed the first versions of the psychotherapy WBPAs (SAPE, PACE, CBDGA and SAPA).

James built on Chess's work, both at core training and higher specialty training levels. James's 2012 UK Psychotherapy training survey with Barbara Woods and statistician Adrian Husbands, was instrumental in showing that training schemes that had a Consultant Medical Psychotherapist in the role of Psychotherapy tutor were statistically more likely to ensure psychiatric trainees were achieving their psychotherapy competencies at the end of Core training. The GMC supported this, and it became a GMC requirement by March 2015 that all training schemes needed a Medical Psychotherapist in this role. There was a period of derogation for training schemes to put this in place, develop jobs and recruit Consultant Medical Psychotherapists to fulfil the role, and this development has been fundamental in securing the future for Medical Psychotherapy, significantly in regions where there had been an absence of Medical Psychotherapy colleagues. One of the essential provisos that we then ensured was incorporated into the curriculum was that the Psychotherapy tutor role needed a clinical context. That is, training schemes and Trusts could not just employ a Consultant Medical Psychotherapist purely to fill this educational role but there needed to be a clinical role alongside this. We need to be seeing patients, keeping clinically alive and active to be able to supervise, and to have a setting for our work, and for our trainees. These may seem like fundamentals, but they are constantly under pressure when psychiatric services are under-resourced, struggle with retention, recruitment, and to meet acute psychiatric needs.

James' other major contribution was in developing higher dual training in Medical Psychotherapy and General Adult Psychiatry. Dual training had existed prior to this at small scale in Medical Psychotherapy and Forensic Psychiatry. James established the dual scheme with General Adult Psychiatry in his area in Leeds, alongside developing the dual MP-GA curriculum and gaining GMC approval. The Yorkshire scheme was an integrated dual scheme where trainees undertook a combination of the specialties throughout their week. Subsequently dual training has become the norm for Medical Psychotherapy higher speciality training in the UK and the mode of delivery has become sequential for practical reasons. The popularity of higher dual Medical Psychotherapy training is evidenced by 100% fill rates and higher training being oversubscribed. However there are still difficulties further down the cycle to recruit at consultant level, which I will return to shortly.

The 2016 Psychotherapy survey which the SAC undertook and I reported on with Adrian Husbands in 2018, (med-psy-psychotherapy-survey-2018-with-2016-data.pdf (rcpsych.ac.uk)) reinforced what James had found in 2012 in respect of Core training and the role of the Psychotherapy tutor, and that psychotherapy training competencies, especially the qualitative experience of undertaking the long case, usually in psychodynamic psychotherapy, were more likely to be fulfilled where there was a Consultant Psychiatrist in Medical Psychotherapy in post as Psychotherapy tutor and where there was an appropriate setting for the work. The survey showed that this was adversely affected by closure of secondary care Psychotherapy services. However colleagues were also creative in adapting to transformation by developing innovative care pathways for training patients and developing relationships with IAPT for short cases.

The survey also found dual training had become prominent in Specialty Medical Psychotherapy training with only some single CCTs. Also surveyed was that some other higher speciality trainees undertook a SAPE as part of their yearly portfolio assessment for ARCP, which led on to the SAC developing guidance on this for other psychiatric specialities.

We have moved on since then and the curricula rewrite has consumed the work of the SAC over the last three years – we finally have new curricula supported by a structure that has taken painstaking work. The 'Silver Guide' for Psychiatry and a Core and Specialty Medical Psychotherapy curriculum, supported by: Placement-specific personal development plans (PDPs); 'End of Year Standards Guidance' , the curricula HLO key capabilities that a trainer might expect a trainee to achieve for a given year of their higher training; and new psychotherapy WPBA's aligned to the new curricula structure. The latter have had some delays in uploading to the electronic portfolio but will be in place soon and pdf versions are available on the RCPsych curricula hub. (Curricula documents and resources | Royal College of Psychiatrists (rcpsych.ac.uk). Please get in touch if there are areas of concern that you would like to see strengthened and improved. At our last SAC we discussed the 'Psychotherapy Supervisor's Guide' for trainers. We are updating this to strengthen it and align to the new curricula structure and this will also be uploaded as a resource.

This leads onto my concluding reflections. The work of the SAC is perennial – a constant need to keep psychotherapy training alive, maintain the setting and boundaries through formal structures to ensure the fundamentals are in place so there is potential space for creative relationships for trainees and their patients. This then allows for understanding, development, and growth for trainees as psychotherapeutic psychiatrists as part of the spiral curriculum, and compassionate, psychologically attuned psychiatry.

There is work still to be done as recruitment at consultant level outside of the big urban centres, especially London, remains problematic. There is an increase in national training numbers at core level and we need to be able to expand our higher training numbers alongside other specialty trainings. This needs to be adequately resourced so regions where there are single or a small number of specialty higher training posts can have viable academic programmes. I would like to see regional centres that are financially supported to provide high quality academic programmes to accommodate the proposed expansion. The evidence suggests that trainees will tend to settle where they have undertaken their specialty higher training, and with strengthening of regional programmes this would address hard to recruit regions.

Dual curricula mapping to new curriculum needs undertaking. I will be remaining on the executive and look forward to supporting my successor in progressing the work of the SAC and Faculty as a whole.

The NHS Workforce and the Covid Pandemic: the need to reflect, to mourn and to learn

Jo O'Reilly
Consultant Psychiatrist in Medical Psychotherapy
RCPsych Chair Medical Psychotherapy Faculty
Member Reflective Practice Working Group

In response to the crisis in the NHS workforce in the wake of the covid-19 pandemic, a Workforce Wellbeing event was hosted jointly by RCPsych and Doctors in Distress at Prescot Street on 11th May 2022. Adrian James and Clare Gerada opened the event and attendees included NHS leaders and policy maker across medicine and surgery, including the BMA, GMC, HEE representatives from nursing, midwifery, the devolved nations and heads of the Royal Colleges. It was held as a reflective event and members of the Medical Psychotherapy Faculty, led by the Reflective Practice Working Group, facilitated both small and large groups which provided the spaces for experiences to be shared and ideas to be developed. An outcome of the event was for an open letter written by Adrian and Clare with other signatories from the event to be sent to Chris Whitty and Amanda Pritchard, Chief Executive of NHS England, requesting reflective practice spaces be made routinely available for all NHS staff in order to support them to process the emotional impact of the work they do.

I was asked to open the day with an introduction which may be of interest to readers of this newsletter and is published below. We were delighted that the Medical Psychotherapy Faculty were able to contribute to this event and demonstrate the importance of well-run reflective spaces at this event.

Introduction

Good morning and a very warm welcome to you all.

Our task today is to think about the challenges we are facing in the wake of the covid-19 pandemic with an extremely precious resource - the NHS workforce. In accommodating this event at the RCPsych, jointly with our colleagues from Drs in Distress, we are firmly placing our focus upon the emotional and psychological needs of NHS staff. We will be drawing upon all the expertise and experience in this room- we are a potentially powerful group of people holding leadership roles which are highly meaningful to NHS staff. We have a real opportunity today to shape the future direction of travel in how the emotional and psychological needs of NHS staff are considered. This is a short day, we are looking for outcomes, and I am just going to speak for a few minutes to further set the scene.

This is a different kind of event to previous meetings you may have attended. We are giving priority to the process of reflection as the basis for learning from a crisis. We will be asking you to look backwards and draw upon your own experiences of working during the pandemic in order to develop our ideas about what is needed going forwards. We will be working in both small groups and as a large group in order to strengthen our collective learning. This is not about being talked at or presented with new data. Instead we are asking you to turn your emotional antennae inwards, to consider your own challenges, and what has helped, to connect with each other and to openheartedly contribute. There is no need for you to take notes today - outcomes will arise from our discussions and will be sent to you all afterwards.

In addition to our professional identities we all have had our individual experiences of the pandemic and our vulnerabilities have been exposed and fear raised as partners, parents, sons, daughters, siblings, friends, colleagues, and patients. This is not about those who have struggled to cope and those who have not. There has been a level of threat directed at us all, and none of us have been exempt from fear or loss. We have all faced severe restrictions to our agency, activities and relationships. Some of us may have been and continue to be unwell, and many have lost colleagues and loved ones. NHS staff are leaving… the term mass exodus of staff is being used in my own workplace and our psychiatry trainees don’t want to fill posts being vacated by consultants.

And I can understand this. Clear divisions between patients and staff, the vulnerable and the invulnerable, have fallen away, and staff have been put at risk and very frightened at work. Infection control measures and absences have left us isolated from our colleagues and our usual networks of support. There has also been a process of accelerated learning and many of us will have found creative adaptations, tapped into deep resources in ourselves and our teams. If we can learn from each other about the essence of what we need at work, what helps us to continue whilst feeling vulnerable, overwhelmed and afraid we are well placed to come up with policies which are meaningful and in tune with the emotional experiences and needs of our colleagues.

NHS staff have always faced traumatic events, their work places them intimately close to suffering and death, and the emotional toll of this has been intensified during the pandemic. NHS staff also have experience of working together in effective and deeply moving ways when faced with the starkest of experiences and under intense pressure. The organizational culture really matters, and staff are often acutely aware of how the organizational factors can powerfully influence their experience at work. To be supported with and to be able to reflect about the emotional impact of the work should be a fundamental right when your work places you so intimately close to suffering, to hold such responsibility, and yet this is habitually neglected in the NHS.

Collectively we are all faced with a task of mourning- not just for the many losses/ bereavements we have faced, but also for previously held certainties and idealisations. We all want to believe that our leaders will know what to do in a crisis and will keep us safe but this has been an impossible position for those in leadership roles to sustain- we have had to learn and adapt as new information has emerged about the trajectory and effects of the virus. Mourning in this sense is a deeply creative process, allowing us to relinquish what has gone before, what may no longer be available to us and to accept new realities. If we are unable to mourn, we can become stuck and our ability to learn from what a crisis may reveal and to make necessary changes is compromised.

Loss, then, includes a loss of faith in an NHS which is able to meet the needs of patients and to keep staff safe at work. This is very painful when many NHS staff give above and beyond to their work and tolerate any challenges out of deep commitment and love for what they do. Moral injury and traumatic experiences have powerfully added to the emotional and psychological impact of the pandemic, but we are also faced with the pervasive impact of deep disillusionment, exhaustion and anger about the conditions under which staff have had to work. This may be no one's fault but needs to be faced if healing is to occur.

Many of these issues are not new. Covid has highlighted the effect of underfunding and inequalities which pre-date the pandemic. For many it has been the final straw for a workforce which has been struggling for a long time. In doing so covid has also highlighted the inescapable need to reconsider how we care for staff, so they are able to provide care for patients.

In the mental health trust in which I work we carried out a survey of trainee psychiatrists and their experience of working during the pandemic. The most striking finding was that none of them had been asked. We dedicated an afternoon to meet, and it was really constructive - distress, anger and grief were all expressed, and how isolated many of them had felt - with accompanying thoughts of leaving the profession. Creative solutions and learning also emerged from this open discussion. What the trainees had found helpful contained very few surprises - feeling connected to and valued by their teams, that their managers wanted to know about their experiences and that this would inform policy, and to have spaces they could rely upon to reflect when difficult things happened.

We all have our psychological defences which we may not be aware of, and which can both help us during a crisis and also make it more difficult to make good decisions once the crisis has passed. When under threat our defences may lead us to minimise or deny the enormity of what has happened and the wish to simply carry on or return to a "new normal" may be powerful. The urge to regain a sense of control can lead us to become overactive, such as to decide upon major new schemes or service redesigns, which can add to anxiety for staff just when they need time to process what has happened. There can be a real pull towards activities which distract us from facing painful realities. This means opportunities to learn and to put in place what is needed will be lost, and feelings of disillusionment and anger will likely contribute to further leaching away of NHS staff, their goodwill, and their commitment.

There is a difference between decisions made and actions taken on the basis of an openhearted engagement with painful experiences and a desire to learn from what the crisis has revealed, rather than a need to defend ourselves against feeling vulnerable, helpless or anxious.

Reflective spaces have a key role to play. There may well be new ideas and structures needed- such as the blossoming of mental health services for NHS staff. It may also be the case we need a cultural change in how we attend to the needs of all staff at work if we are to build a robust workforce which is able to thrive. We all have experience to draw upon and if we can openly consider what have been the major challenges, what may have felt too difficult to manage, our own potential breaking points- and what has helped, the factors which make our work sustainable and pleasurable, we may find have some of the answers already within us. And we can arrive at meaningful outcomes today from this process.

Summary of college letter to Chris Whitty and Amanda Pritchard

The letter from the RCPsych and signed by Adrian James and Clare Gerada, amongst others as described above, contained a request “to make the protection and promotion of staff wellbeing central to the culture of the NHS, through embedding reflective spaces within Integrated Care Systems and NHS organisations.”

NHS pressures as well as moral and professional injury sustained during and in the aftermath of the pandemic were highlighted, including the high proportion of staff experiencing mental health challenges: 51% meeting criteria for probable common mental disorders, 36% for probable PTSD, and 18% for alcohol misuse. There was a call to create cultural change in the NHS in recognising the emotional impact and complexity of the work undertaken in mental health services, and to build on the support services implemented during the pandemic such as staff mental health services and wellbeing hubs, Doctors in Distress etc.

There was a plea to embed reflective spaces in workplaces to provide opportunities for staff to digest and reflect on their experiences and emotional states. This would improve recruitment and retention of staff, as well as staff health, and crucially would allow safe functioning of systems as staff are better able to think about clinical issues and patient care.

Opinion Piece: Views on the treatment of patients with severe and complex Eating Disorders

This article was temporarily removed from the spring edition of the newsletter and is being republished along with a response from the Eating Disorders Faculty.

The two articles below represent two ways of looking at patients with eating disorders, one from an attachment perspective and the other from a metabo-psychiatric perspective. They lead to some different thoughts on management of these severely unwell patients. The original article, an opinion piece by Dr Barzdaitiene which was published in the spring edition of this newsletter, and inviting further thought on treatments for these patients, evoked a response from the Eating Disorders Faculty which has addressed some areas of disagreement in the response from Dr Ayton. We publish both articles here in the spirit of healthy debate. We do not plan to continue this debate further in our newsletter; however anticipate that *these views will spark further thinking about management of complex patients both in the Eating Disorders Faculty and more widely.*

Gripped by Fear: The Invisible Crisis in Eating Disorders Services

Dr Daiva Barzdaitiene
Consultant Psychiatrist, Norfolk Community Eating Disorders Service

I have decided to write this as I can no longer stand by and watch the suffocation of our Eating Disorders services. Over the past few years I have witnessed more and more patients becoming helpless, perpetually institutionalised people, and increasingly fewer professionals wanting to work in Eating Disorders. In this article I would like to concentrate on how the adoption of harmful compassion amongst clinicians, as well as our current legal system, contributes to the ever-growing numbers of severe complex patients and a staff that is stifled by fear.

I will start with a brief explanation of the science of attachment. It has been developing for over a hundred years and our current knowledge in the field is clinically tested and evidence based. I will point out the importance of implementing this knowledge in our current mental health systems.

We know that a good start in life – being born healthy and having a loving family – is very important for the development of our sense of self, our ability to regulate emotions and attention. This early foundation provides an environment for *secure attachment* to develop, which helps us relate to ourselves and to others later in life. Unfortunately, not all of us are lucky enough to have this foundation, and for various reasons (physical or mental illness, traumas, the emotional struggles of our caregivers or our inborn sensitivity to the external world that cannot be met by people who love us) we become *insecurely* attached to the world. This means no stable sense of self and a distorted ability to regulate attention and emotions; in short, we struggle to become responsible adults who are able to reflect on their difficulties and address them.

This might sound quite depressing; if our psychological health depends on the luck of our origins, then there is nothing we can do about it. However, recent findings have shown that the psychological quality of a human life depends not so much on the attachment style, but on *resilience*. Someone might have been brought up in challenging circumstances, and might have developed an insecure attachment; however, if those circumstances provide them with opportunities to build resilience, they would manage and even thrive in life.

If a person has no resilience, they will struggle to cope with regular life requirements, lose the ability to mentalize (the ability to remain in an adult, reflective mind) and start functioning in pre-mentalistic modes (normal in children between the ages of 2 and 7), where attempts to regulate their sense of self, emotions and attention are expressed through actions in the physical world. Examples of these are self-harm, overdosing, restricting food, losing weight and so on – presentations that clinicians working in general mental health or Eating Disorders face every day. Therefore, it is crucial for us to think of how to help build resilience in our patients, so that they can have a better chance of surviving and leading a meaningful life.

As is the case with many clinicians, I have wanted to help people since the early years of my life. This led me to study medicine and become a psychiatrist and a psychotherapist. I always felt privileged to have a profession in which I was able to contribute to reducing human suffering. Through many years of training, work and professional development, I felt I had become a competent doctor who understood that the divide between a clinician and a patient was merely a matter of different areas of expertise, different problems and different skills in addressing those problems. This realisation helped me to enjoy my work and engage in meaningful conversations with my patients (I am using this word for the sake of simplicity, but it would be more accurate to say - in the words of Prof Peter Fonagy – my conversational partners).

Respect for and curiosity about another person's mind were the prime motivations in my work. I was able to maintain this attitude whilst working in two European countries as well as in the UK between 2008- 2013. I left the UK for five years for personal reasons, returned in 2018 and started a new job as a Consultant Psychiatrist in Eating Disorders. Gradually I realised that the atmosphere in Eating Disorders services had changed dramatically since 2013. Fear was all around.

It is no secret that Eating Disorders have the highest mortality rate in mental health and that people die from anorexia five times more than in the general population. The best response to treatment is in the first three years of illness; between the third and fifth year the effectiveness is reduced, but treatment may still produce benefits; after five years however, eating disordered behaviour becomes entrenched and very difficult to treat. It becomes like an addiction, where the sufferer gets a buzz, a sense of happiness from the numbers on the scales going down. The illness becomes part of their identity and gives a sense of joy; the mind shrinks and nothing else matters except low weight. Many years of unsuccessful coercive treatment practices in the UK have shown that it is impossible to help patients get better when they have had an eating disorder for many years and they *have no wish to recover*.

In many European countries, people with long term severe eating disorders are not being chased – they are treated in Eating Disorders services only if they wish to be treated. In France, for example, eating disorders are considered and treated as addictions. It is important to note that mortality rates in these countries are no higher than in the UK.

An eating disorder is not psychosis – people maintain their sense of reality and, most of the time, they retain the capacity to make their own decisions. They may lack insight, but so do people who slip into alcoholism, drugs and other addictive behaviours. We do not treat people with addictions against their will, nor do we force treatment onto a cancer patient who has refused chemotherapy. This raises a question – why do we desperately try to ignore the wishes of patients with a long-term eating disorder? Why do we use resources in chasing them, begging them 'to take a bed', 'rescuing' them when they have no wish to be treated? Especially when these countless attempts to treat people who do not want to change take away resources from the people who have recently developed an eating disorder and could be helped.

There is an attitude in the mental health system in the UK that *no one should die from an eating disorder* (similar to the Zero Suicide policy that was adopted by various mental health trusts in the East of England from 2013 onwards, as part of the East of England Strategic Clinical Network). This thinking might stem from a lack of understanding that an eating disorder is a state of mind and a specific set of behaviours caused by multiple psychological, emotional, biological and social factors. *It is not caused by a lack of food and cannot be treated with re-feeding*.

When I started at my new job, a patient had died a few years ago in our service. The court case was still carrying on, nobody knew how and for what they might be blamed. I saw devoted clinicians going off sick or leaving their jobs, and the service faced difficulties in recruiting. The press took joy in describing the faults of the service and had little interest in describing the hard work that the clinicians were doing every day in trying to treat and support their patients. The service was gripped by fear.

At first, I managed to resist it. In all the previous years of my practice I had been treated with respect and felt free to use my knowledge and expertise for the good of my patients. Sometimes this included decisions not to treat. However, in 2018 I started hearing the phrase 'what if...?' more and more. Things like: 'GPs refuse to monitor, they do not want to be blamed…', 'We will go to court …', 'We need to protect the clinicians'. Alongside conversations as to what might genuinely be best for a certain patient, phrases such as '*but what if'* and *'to protect ourselves'* became more and more dominant, not only within the Service or the Trust, but in the meetings and decision making at regional level.

A few weeks ago, in my team's weekly meeting I heard myself say the words: '*I don't like this patient*'. I was immediately shocked at having said it; I came home and could not forget it. I needed to reflect on what had led me to say something which previously I could never have imagined even feeling. I started to think about the patient, and realised that my feelings of 'not liking' them had nothing to do with the patient themselves, but with the helpless – yet 'dangerous' – case that the system was turning them into. It was the misguided, harmful expectation that *no deaths from anorexia are allowed*, it was the view of me as a potential offender, it was the aftermath of my colleagues going off sick with stress and leaving their jobs, it was the difficulties in recruiting new staff. Ultimately, it was the fear of '*what if'.* Our current mental health system was making me ignore all of my and my teams' expertise, which was clearly suggesting that this patient might do better if discharged from the service, if they have a chance to face the consequences of their decisions. If we 'rescue' this patient against their will, their illness would be perpetual.

The majority of Eating Disorders and general mental health patients have insecure attachment and/or lack of resilience in their background. The science in the field has confirmed that for some people with insecure and avoidant attachment styles, being too close to others overstimulates their attachment system – it increases anxiety and triggers more attachment seeking behaviours. Restricted eating or self-harm starts as a way to regulate unbearable internal states, and we, clinicians, need to be very careful, as over-involvement or 'rescuing' can overstimulate attachment.

We need to support our Eating Disorders patients in a way that brings positive changes. To do this, we need to be able to take positive risks, which means stepping back if there are no changes or if the patient's behaviours are getting worse. This approach is necessary in order to avoid compounding a sense of helplessness in patients, to help build their resilience and finally, to help them get better. We wouldn’t expect a patient with a physical health problem to take medicine that was either ineffective or made their problem worse.

Mentalization based treatment, which is based on attachment theory, talks about ‘keeping the right temperature’ – ‘not too cold’ and ‘not too warm’. The same applies for a holistic understanding of Eating Disorders treatment. To be able to take the right distance and be flexible enough to change it based on the changing situation and needs of the patient is an art and a science. A clinician must feel confident, safe and trusted by the system in order to be able to do this; to be able to make the most appropriate decisions at a given time. A system which forces me not to rely on my experience and clinical judgement but to think of how to protect myself against blame and scrutiny paralyses me as a clinician. To take positive risks in this state of mind is hardly possible. Instead of trying to do what is best for my patient, I am forced to think of how I, myself, can survive.

Below I would like to share my suggestions as to how we can move out of a fear-driven approach to Eating Disorders and towards a functional and sustainable one:

1.Treatment for Eating Disorders should be voluntary in most cases.

2.Treatment against people’s wishes might be justified (after careful consideration) in the first 3 to 5 years of the disorder.

3.If the longevity of a disorder is more than 5 years, only people who ask for help should be treated in Eating Disorders services. Brief medical admissions for stabilisation should be available to everybody but only on a voluntary basis.

4.Mental Health teams, General Practitioners, colleagues from Acute Trusts should be respected for their hard work and not blamed if a person dies from an eating disorder. From an investigator’s retrospective point of view, it is very easy to find things that could have been done differently, but such investigation is carried out in a very different state of mind and position to somebody who works directly with the patient and has to make complex decisions at the time. If a death occurs, a reflection should take place among the members of the treatment team, the same as in physical medicine.

5.Patients with trauma who have problems with eating as a part of their complex presentation should be treated for trauma, considering their disordered eating as one of the ways they use to regulate emotions. A holistic approach is necessary.

If the above suggestions are implemented, in my view, they:

1. Would prevent infantilising the patients by giving back responsibility for their well-being, which would boost resilience and the wish to recover.

2. This attitude would allow professionals working in eating disorders to regain trust in their own skills, maintain curiosity, and would increase the attractiveness of working in Eating Disorders, all of which would in turn benefit patients.

3. Resources could be used mainly in early interventions to help people return to a meaningful and responsible way of living. This could have a ripple effect on their future, family and society.

4. The current ‘bed crises’ would be alleviated as only the patients who benefit from an inpatient treatment would be admitted.

I hope that my ideas will open a discussion and facilitate positive changes in the treatment of Eating Disorders.

Response to Dr Barzdaitiene’s opinion piece

Dr Agnes Ayton, MD, FRCsych, MMedSc, MSc
Chair of Faculty of Eating Disorders, RCPsych

When Dr Barzdaitiene's article was brought to the attention of the Faculty of Eating Disorders, the tone and content of this piece, which contains several inaccurate and unsupported claims regarding the nature and treatment of eating disorders, caused grave concerns. We appreciate the opportunity to respond following the letter's temporary retraction.

Dr Barzdaitiene conflates various issues that should be disentangled.

We agree that severe underfunding of adult eating disorder services has led to an unacceptable degree of risk, staff burnout, and has contributed to poor recruitment and retention. The pandemic has increased the already high stress levels of patients and staff. However, the response to overwhelming pressure should not be to compromise patient safety or to remove patient care. These problems could be alleviated by investing into NHS services.

Dr Barzdaitiene begins her case with the assertion that *‘adoption of harmful compassion … as well as our current legal system, contributes to the ever-growing numbers of severe complex patients and a staff that is stifled by fear.’* These are factually inaccurate claims: a rise in eating disorder trends has been found worldwide.[1-8] She then offers her opinion on insecure attachment as the leading cause of eating disorders.[9] In contrast, recent research has indicated that anorexia nervosa is a metabo-psychiatric disorder with a significant genetic basis,[10-12] and that the various types of eating disorders have distinct causative pathways.[13]

In perhaps the most disturbing section of her letter, she describes the high mortality rates in eating disorders as inevitable, without considering how they could be reduced and claims that policies stating that no one should die from an eating disorder ‘*might stem from a lack of understanding*’ of the nature of eating disorders. This comment is extraordinary and inappropriate. Eliminating preventable mortality is a crucial policy objective. This does not imply that deaths are always preventable, but specialised services, researchers and policymakers must and should focus on reducing preventable deaths.

The Faculty of Eating Disorders has recently published the 'Medical Emergencies in Eating Disorders' guidelines (CR233),[14] which are designed to aid clinicians in managing life-threatening emergencies safely and to prevent avoidable deaths. These guidelines were developed through extensive collaboration with many stakeholders. We are pleased that the

Academy of Medical Royal Colleges has approved the guidelines. There is an entire chapter devoted to compulsory treatment and capacity; duration of illness is not used as a parameter to determine access to treatment, regardless of legal status. In May 2022, the subtitle of the launching event was 'Making preventable deaths due to eating disorders a thing of the past'. It was disappointing to learn that a colleague in the same discipline had contributed an opposing viewpoint to a separate Faculty's newsletter at around the same time, without consultation or consideration of the potential consequences on clinical practice.

Dr Barzdaitiene asserts that '*after five years... eating disordered behaviour becomes entrenched and very difficult to treat. It becomes like an addiction, where the sufferer gets a buzz, a sense of happiness from the numbers on the scales going down*'. This is an inflammatory statement without any evidence offered to substantiate it. While abnormalities in the brain's reward pathways have been investigated in relation to eating disorders, they are neither specific nor time sensitive.[15, 16]

When she states that eating disorders "*cannot be treated with refeeding*," Dr Barzdaitiene also minimises the effects of malnutrition on the brain. Malnutrition is a key maintaining factor, and the NICE guidelines[17, 18] make it clear that weight restoration is a crucial component of psychological treatment for anorexia, as reversal of malnutrition is a robust predictor of good outcomes.[19-21]

She recommends that '*If the longevity of a disorder is more than 5 years, only people who ask for help should be treated in Eating Disorders services',* ignoring the huge amount of shame, anxiety, and institutional barriers that may prevent people from receiving early treatment. A recent study found that the average length of delay between onset of eating disorder symptoms and treatment-seeking was 5.3 years.[22]

She asserts that despite the severity of their illness, people mostly retain their capacity. This is dangerous nonsense. The idea that compulsory treatment for eating disorders should not be considered after three to five years, with care being offered solely to individuals who request it, is contrary to good medical practice and would not be acceptable for any other mental illness – as it will increase premature mortality. This was sadly demonstrated by the tragic outcome of a recent Court of Protection ruling.[23] It is well known to all those who have worked with or cared for someone with an eating disorder that the likelihood of seeking and accepting help significantly diminishes in parallel with illness severity. It would therefore follow that this proposal actively seeks to exclude patients who are most in need, as they are least able to ask for help. Obviously, every effort should be made to engage the patient in voluntary treatment, but the Mental Health Act (MHA) has no time constraints on the patient's illness duration or age. Eating disorders are the same as any other mental illness in that, after many years, individuals can benefit from treatment.[24] Compulsory treatment can be lifesaving, and patients and carers recognise that it may be helpful and necessary.[25, 26]

Dr Barzdaitiene poses the following question: '*why do we … ignore the wishes of patients with a long-term eating disorder?*' We do not view this as cruel or futile; rather, we view it as maintaining hope when the patient and his or her family cannot. With persistence and assistance, the majority of our patients are able to tolerate their emotional world and, in turn, their bodies. We are also aware that persistence can make us feel cruel; this is an effect of the illness, and it is our responsibility to work as a team to overcome this. Because we share the same burden, we have compassion for all clinicians. This collusion is a frequent occurrence that necessitates intense teamwork on behalf of the patient. If the team is unable to do this, the patient will feel unsafe and as though they might as well die because no one can combat their illness.

Dr Barzdaitiene proposes that *'Brief medical admissions for stabilisation should be available to everybody but only on a voluntary basis'.* This is in contrast with the evidence that suggests that admissions for partial weight restoration are ineffective and result in high relapse rates.[19, 20] Both biological and psychological factors must be addressed for optimal outcomes.

While we share Dr Barzdaitiene concerns regarding the impact of patient deaths and coroner's investigations on staff, we disagree that these difficulties are unique to eating disorders: life and death are inherent to working in healthcare across all medical and psychiatric specialties and represent the most challenging situations. It must be emphasised that, despite the emotional impact on professionals and families, coroners play a key role in improving patient safety and identifying measures to prevent future deaths. The PHSO report, for instance, highlighted how NHS eating disorder services for adults are failing patients due to inadequate funding and training, and made helpful recommendations, which are gradually being implemented.[27, 28] We should not shy away from identifying service deficiencies, as this is the first step in bringing about change.

Dr Barzdaitiene contrasts staff well-being and patient safety as though they were distinct. This is a false and dangerous dichotomy, and it is not an appropriate way of presenting moral dilemmas in chronically underfunded services that are frequently unable to provide timely access to NICE-approved treatments owing to insufficient staffing.

While we agree that there are serious service challenges, we see different solutions. These include increased training in eating disorders for all psychiatrists[29]; advocating for adequate funding and workforce development to ensure NICE,[17, 30] NHSE[31] and MEED[14] guidelines are implemented across the age spectrum and without delay or discrimination; increasing investment in research for new and more effective treatments;[32, 33] and strengthening coordination between various faculties and policy efforts within the College.

The Royal College of Physicians collects frontline accounts. Similarly, our College may consider the collection of anonymous reports of difficulties and solutions by psychiatrists, patients, and carers, and a summary of this information could subsequently be utilised to influence national policy and improvement of patient care. Staff burnout and dangerous caseloads are becoming increasingly common in the NHS, resulting in poor recruitment and retention across professional groups, including consultants. The Royal College of Psychiatrists must start addressing this for the benefit of patients and psychiatrists.

There are also further issues highlighted which need attention across the College, namely that the implementation of the new MHA will require careful attention to avoid excluding severely ill patients who may refuse treatment.

The challenging issue of palliative care in psychiatry may require a position paper involving all faculties, especially in the light of the recent Court of Protection decision.[23] However, we should not treat eating disorders differently from other mental disorders, as there are major overlaps with many mental conditions.[34-36]

Signed by:

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Trainee Voices

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Dr Hafeesa Sameem, CT2 Gen Psychiatry, South Wales

Introduction

Josephine Fielding, Dr Alan Baban and Dr Sophie Stokes
Faculty of Medical Psychotherapy Trainee Reps

Firstly, a warm welcome to those who started their Medical Psychotherapy higher training in August, and welcome back to everyone else after the summer break. As psychotherapy trainee representatives we are delighted to announce our new rep Dr Sophie Stokes, a Forensic Psychiatry and Medical Psychotherapy dual ST in the West Midlands, who has extensive experience representing trainees. She is joining us after Dr Anna Croxford stepped down after reaching the end of her training. We also wanted to say thank you to Anna for all her work as trainee rep over the years and many congratulations on her CCT.

In May 2022 we held the first Medical Psychotherapy Trainee-Trainer Conference since the start of the pandemic, on the theme of Loss and Regeneration. Taking place at the Freud Museum in London, it was a real joy to see many trainees there, and to have the chance of being together in person again after so long. It felt especially fitting that one of our speakers, Dr Marchelle Farrell, winner of the 2021 Nan Shepherd prize in nature writing for her book 'Uprooting', was a former trainee representative herself, and had organised one of these conferences in a previous year.

We are now at work planning the 2023 conference, which will be held in Birmingham. This will be a unique collaboration between medical psychotherapy trainees and psychART (https://www.psychart.org.uk/), a trainee-led initiative exploring psychiatry and the arts. Do keep an eye out for further updates on the conference – if you'd like to register your interest in advance, please email the conference committee on: mptrainertrainee@gmail.com.

We've also been looking at building more links with other trainee reps and faculties, and this was highlighted in the joint Faculties of General Adult Psychiatry and Medical Psychotherapy spring conference, where the medical psychotherapy reps co-chaired a session together with the general adult Faculty reps, exploring the importance of relationships in training.

There are a lot of opportunities via the Faculty for trainees to get involved, so we would encourage interested trainees to get in touch with us, and to keep a look out for projects you might want to take part in. We are currently using the trainee WhatsApp group as our main means of communicating with trainees and it's an easy way to connect with others and share news and queries. If you're a Specialty Trainee in a psychotherapy training programme in the UK and you're not already a member of the group, please do email us on mptraineerep@gmail.com to be added.

On a more sober note, we have in mind the potential BMA ballot for industrial action, and that this could have a particular and complex impact on those working in medical psychotherapy. We will be considering how best to support trainees with this if things progress further, including the possibility of arranging some ad hoc meetings as a thinking space for medical psychotherapy trainees.

We continue our regular trainee meetings (currently online) which are a way to keep up to date but also for higher trainees in psychotherapy to get to know each other and share experiences across the different regions. The meetings are very informal, so do drop in even if you can't stay for the whole thing. Our next meeting is planned for **Wednesday 16th November** – please do keep an eye on the WhatsApp group for details or email the rep address to be sent the link.

Looking forward to seeing many of you at the next meeting!

Musings on the perceived challenges of online therapy

Dr A Alalade
ST6 General Adult Psychiatry, SHSC, Special Interest in CAT

I have always had my doubts about online therapy, with near-luddite tendencies. But it's time for me (and others like me) to accept it is here to stay. My doubts persisted despite finding myself in alternating roles of client and therapist at varying points using electronic media. Because I have been in both roles, I can say confidently that receiving therapy is not quite the same as giving therapy online. Many people find online therapy convenient. It is a lot easier to attend than enduring a drive or bus ride while becoming consumed with one's distressing thoughts, the object of which we might want the therapist to explore; and for some it reduces the anxiety of being in a new environment. Some would argue that online therapy is kinder on the environment, consequent to less travelling time, burning natural gases.

That online therapy is the future, is not necessarily big news, but it is important to acknowledge that some people have anxieties about delivering therapy online, especially as we are only just starting to develop our experience. For more experienced clinicians, it can be daunting to adapt to a new style of working after settling into a routine with good outcomes, although a large-scale international longitudinal survey (Bekes et al, 2021), found out that *older and more experienced therapists perceived fewer challenges of any kind in their online sessions*. This could likely be related to the fact that our own fears, preconceptions and expectations while delivering therapy, irrespective of the medium, could adversely affect the efficacy of the therapy process itself. It therefore makes sense to reflect on how we can minimise these fears, confront our preconceptions and make adaptations to our practice.

The COVID-19 pandemic drastically altered our routine in almost all facets of our lives, and the means of providing psychotherapy was no exception to this. Many clinicians had never thought much about any form of online therapy. Very few of us had received any robust training, and even any training at all was hurried due to the urgency of continued service provision under pressured circumstances. Over two years later (which feels like many years later) certainly most of us have learnt a lot and maybe even have an improved confidence. Online therapy also regarded as "Teletherapy", tends to create some anxieties for the therapist. Some of the main challenges often cited include:

1. The issue of attention and presence: We wonder if the person is fully invested or distracted by everyday events at home. The ideal therapy situation involves *being with* a client rather than *doing to* a client. Being on front of a screen sometimes creates mental associations of "doing a presentation" and doesn't feel quite as intimate as a client being in the same room. The therapist is also at risk of distraction, especially from mails or notifications on the laptop.
2. Feeling like losing control of the environment: The therapy setting tends to be one in which the therapist exerts some control over the environment, including the sitting arrangement, having a tissue box nearby or the positioning of the clock. For the therapist working online it can feel like losing a measure of control of the situation.
3. Concerns about the impact of technical glitches, and level of internet/ technology literacy of the therapist and client: there are varying degrees of confidence with using any electronic gadgets. Younger clients generally feel more confident with online therapy compared to older clients. I have certainly observed this as well in practice.

So what can we do about these?

1. I think it is important to explore with the patient their reactions to coping with technology, and of course, always offer choices first, whichever is most comfortable. All of these could be discussed in the agreement.

2. Also we should try to stay still and imagine we are in the same environment with the patient. We can attempt to set up the camera in a manner that the body is visible. and some hand and body movements are equally visible for both participants. This can create a sense of connection, and with gradual practice, and improving therapeutic relationship, hopefully diminish that sense of disconnect over a screen.

3. One way to manage losing control is to give clear instructions on creating a safe and holding environment with no interruptions. A clear positive from this is helping to improving adult coping strategies.

4. Ultimately, it is important as video therapy starts to become the norm, rather than the alternative, that further training is provided to therapists, taking cognizance of the way the world is changing.

Parents' Club

Dr Kasia Moczynska

Full time CT2, mum to 3 little humans and 1 dog

Dear Junior Doctors,

As some of you have noticed, HR have missed sending you the invitation for Parenthood Induction for Junior Doctors during your last placement. Sorry for any inconvenience. Hope you find the attached minutes helpful.

Congratulations! You are having a child! A massive life change that nobody is prepared for. It took you years to prepare for your junior Doctor role. This time, however, the change happened overnight. There was no slow transition into it. Here's your baby. You're a parent! A working parent! Sink or swim! You should not give up on parenting responsibilities to child/children you love. You should not give up on a career you love. Everything is adaptable and all you have to do is to find a perfect compromise that works for you and your family. The deanery is there to help you and support you through this journey.

1. *Complete mandatory training*

Read parenting articles and books. Listen to parenting audiobooks and Tedtalks. Complete webinars and courses through SuppoRRt Programme. Some taster days are usually easy to organise with your friends/family who already have children.

2. *Your placement*

It takes a village to raise a child. If you have no/not enough support locally, surround yourself with supportive people, and you, yourself be that person. Make a 'good friends' circle at the school gate with other parents, at football, at dance classes, everywhere your child attends! Join social media groups who share similar struggles. Find your village! I cannot tell you how many times I was reminded on WhatsApp to bring £1 for a charity or a non-uniform day. They offered me help with childcare when they saw me absolutely shattered after work at the nursery gate. They are lifesavers when you are stuck at work/traffic and cannot pick up your little one on time. Ask other junior doctor parents for tips.

3. *Buddy*

Hopefully, you are lucky enough to have supportive partner and have chosen him/her wisely. Someone who shares domestic and childcare duties equally. Be reminded, medicine pushes us into macho positions of coping therefore learn to talk about feelings early. Appreciate your partner. Set a family WhatsApp for nursery/school, wraparound care, grocery lists. Share your calendars. Help each other. When you enter the house after work and see your partner struggling with children, put a superhero cape on, allow your partner to have some noise-free time and sort out moaning children yourself (even when you are also tired).

4. *Design your timetable*

Sit down with your buddy and design a timetable together. Ask yourselves the question 'Why do you work?'. Check how much money do you need to survive, how much to enjoy your life and how much can you maximum earn. Does one/both of you need to compromise on achieving work goals and concentrate on childcare instead? Can one/both of you drop some working hours? Any other options for childcare? Don't forget about emergency childcare. Do not compare yourself with your work colleagues. Stop seeing consultant post as the endpoint life goal. It's just another step. If you can and need to slow the journey to the pace that works for you, go less than full time and enjoy the ride with your family. Becoming a locum is another option to consider. Remember to re-design your timetable as often as you need.

5. *Sign up to team training early*

You should really spend some regular quality time with your partner. As a couple and not parenting partners. Just two of you. It’s impossible not to nag each other when you’re exhausted working parent. It’s okay to go for a meal during wrap around care. It’s difficult to find time and energy. It’s okay if sometimes you prefer to spend the evening together but apart, heads turned in different directions to your respective phones and scroll social media. All working parents have been there.

6. *Jobs list*

Don’t even try to do all home jobs by yourself. There are not enough hours in the day. Lower your standards and ask for help. Working parents cannot easily match up to high standards society has created for them. Never allow anyone to make you question yourself: are you good enough parent, are you good enough junior Doctor, are you good enough working parent? You are more than enough! Managing to keep everything together with a child and a job is already an achievement.

7. *Ask your team for help*

If someone (friends/family/neighbours) offers you help, take it with both hands! Never say no, even when you think you are coping, be it professionally, peer or personally. Free up as much time as often as you can. You might be able to afford a nanny, a cleaner, a gardener, a decorator. They will earn more than you per hour but coming home to a slightly sorted out house is worth it in savings on couples therapy! Use your hard-earned money to buy you time.

8. *Meal breaks*

Of course it is not okay to feed your child frozen peas and fish fingers. They cannot eat frozen food. Microwave it before serving! Get any gadgets that will speed up the cooking process, extra points if they save energy as well. Make a family dinner at mother-in-law’s a regular routine (and ask to take home leftover roast chicken for the next day’s lunch). Pay for meals if you can afford it as it will free lots of time for cooking and cleaning. Check out batch cooking and order groceries online.

9. *Carer’s leave*

You are at the beginning of your ‘junior parent’ role so don’t expect yourself to be at the level of ‘consultant parent’ role. Do you really think you are able to work from home with a toddler with chicken pox having a proper tantrum because you’ve just ruined their day by turning on the wrong episode of Peppa Pig whilst trying to feed them their favourite yoghurt with the wrong colour spoon, not to mention you are sleep deprived for the past couple of years. It will not work. When you need time off to look after your little human, you need time off. You are replaceable at work so don’t let your family life suffer to build a career when little one is unwell, it’s not worth it.

10. *Annual leave*

You thought it is difficult to book A/L together with your partner at the same time? Well, try to book it together during summer school holiday, when you rotate to new Trust in August and not rob the bank to afford it! Request your holidays way in advance. And always go for it!

11. *Sickness leave*

Look after yourself. Always put on your oxygen mask first before helping others. Whether it is burn-out or just a sickness bug brought home by your cute child licking all the surfaces at the nursery. Attend GP appointments when you need to. Use practitioner health. Look after your mental health. Do you need to complete few coaching sessions? They're free through SuppoRRt programme (also some deaneries offer these free of charge).

12. Wellbeing

You go from belonging completely to yourself, to belonging almost entirely to someone else. Weekends, nights, holidays, during and after your Doctor work. There are no rest days. Choose your escape and enjoy it. Whether it's fitness, a haircut, a cuppa with a friend or a relaxing bath. Make sure this time is yours alone (not work and not children). Pay for it if necessary. Instead of feeling guilty, be good to yourself, you are doing this for your family. Happy parent means a happy child.

13. Study time and exams

Replace less-efficient revision practices with evidence-supported, time-efficient revision practices that save time and are more effective for knowledge retrieval in work and in exams. Set your exams as your priority and pass them as soon as you can.

14. Dealing with negative feedback

Children know how to push our buttons. They compare us with other parents who can pick up their kids every day, go to all school trips, attend every speech day and every school play. They can't help comparing with their friends because that's what we all do. Accept that everyone feels guilt, working or not. Cherish the time you do get together and do what you have to do. You're setting a fantastic example of amazing work ethic and a hard-working parent role model!

I love being a parent! I love being a junior Doctor! Good luck with your journey! Enjoy this amazing and unique experience and welcome to the Parents Club!

Cognitive Behavioural Therapy for Psychosis: What can we learn from trainees' reflections?

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Summary

Doctors in training often encounter patients with psychosis in acute or emergency settings, with comparatively fewer opportunities to see them in recovery. Current National Institute for Health and Care Excellence (NICE) guidelines recommend that patients with schizophrenia should be offered individual Cognitive Behavioural Therapy (CBT). [1] However, those with more chronic symptoms under the care of community mental health teams may have less access to this therapy compared to those presenting to early intervention services. Supervision of trainee doctors in the provision of CBT is key to widening access to this valuable therapy for those who need it most. In this article, three trainees share their reflections from offering CBT to patients with psychosis and how this experience challenged their preconceptions.

Background

The Royal College of Psychiatrists mandates that core trainees carry out two psychotherapy cases during their core training, [2] one of which is a long case and one of which is a short case. There is also a requirement to continue developing psychotherapy competencies in higher training.

In Leeds and York Partnerships Foundation Trust trainees have the opportunity to take on a CBT case (short case) under supervision. Some schools of thought are that training cases should be straightforward, possibly accessed through Improving Access to Psychological Therapies (IAPT). However, the thinking in Leeds is that our trainees are unlikely to be working in Primary Care in the future, are more likely to be working with complex cases involving risk and severe mental illness, and indeed with their training background are excellent at working with this patient group.

Whilst cases often involve patients with severe depression or anxiety and suicidal ideation, another group of patients that trainees do well with are patients with psychosis. NICE recommends that all patients with schizophrenia should be offered CBT, and whilst this is well provided for in early intervention services, those with more chronic symptoms who are under the care of Community Mental Health Teams (CMHTs) may have less opportunity for this therapy. Whilst CBT for psychosis does not “remove” psychotic symptoms such as voices or delusions, some studies have suggested that the distress or depression associated with these symptoms can be reduced through CBT. [3]

Doctors in training often see patients with psychosis when they are very unwell and have less opportunity to see such patients in recovery. In the recovery phase many people will experience anxiety symptoms for example, or have problems with low self-esteem, and it is these problems that often can respond well to CBT.
With this in mind, three trainees over the last 12 months were allocated patients with psychotic symptoms, and this paper seeks to share these trainees’ reflections from working with this patient group

Case 1

My first practical exposure to CBT for psychosis occurred in my third year of core psychiatry training. Up until this point, my experience in the management of psychosis had been limited to pharmacological interventions in both inpatient and outpatient settings. Although I was able to witness a number of success stories, it became evident early on that psychotic symptoms can be notoriously difficult to treat, and their persistence can be discouraging for both those receiving treatment and clinicians.

With these experiences in mind, the prospect of delivering a course of CBT was at first intimidating. I was uncomfortably aware of my limited knowledge on the subject and unsure of my ability to shift from a diagnosis driven medical approach to a formulation driven intervention. Familiarising myself with the evidence base that exists for CBT helped allay some of my initial reservations. More importantly, weekly group supervision provided a supportive environment to explore my anxieties about the process and seek advice. This helped build my confidence in the potential of this therapy to make a meaningful difference and my ability to deliver it.

Social distancing regulations as a result of the COVID-19 pandemic meant that sessions would have to be carried out over video-link. At face value, this seemed like another potential barrier to building a therapeutic relationship. However, this experience taught me that some people actually find it easier to explore the challenging topics that can come up during therapy from the safety and comfort of familiar surroundings.

The first few sessions were dedicated to exploring key internal and external events in the person's life that led to the development of their symptoms. The loose structure of these exploratory sessions challenged my prior misconceptions of CBT as being strictly formulaic. I soon learned that providing the person with an opportunity to freely share their experiences and explore the emotional impact of their symptoms set the foundation of a strong therapeutic alliance. From this starting point, it was possible to formulate the person's problems, identify therapeutic goals, explore problematic beliefs about their symptoms and collaboratively develop alternatives.

The opportunity to deliver CBT reinforced my belief in a holistic approach to treatment of psychiatric disorders. I was able to witness first-hand how CBT can provide people with the space and vocabulary to make sense of their symptoms while reducing the emotional distress associated with them, as also described by Turkington and Dudley. [4] My main takeaway from this experience is that regardless of how complex a therapy modality may initially seem; genuine curiosity and empathy are the starting point of any successful intervention.

Case 2

My initial thoughts relating to the case were that of anxiety about delivering CBT in this context, as it may be more challenging. As the case progressed, it became apparent that the skills I had developed through seeing other types of problems for CBT, such as worry, were transferable. This meant that rather than the situation being an anxious thought and the subsequent problem being thoughts and behaviour relating to this, the situation now became the voice-hearing experiences.

As part of the formulation, we spent multiple appointments mapping out a detailed timeline of personal history and history of symptom onset including relapses and periods of remission. The person undertaking CBT found this helpful. It also allowed me to get to know the person and understand their experiences on a level that was more in-depth than I have been able to in other areas of psychiatric practice. This means that as a professional, you are also able to learn unexpected things from a patient that can be applied to other areas of day-to-day practice.

An unanticipated learning experience was how my perception of severe and enduring mental illness could be challenged by meeting a range of patients in different contexts and settings. My prior experience of psychotic illness had been primarily in the acute inpatient setting where you are likely to encounter the most unwell patients. In the context of a medical psychotherapy appointment, the person was not in crisis and had minimal functional impairment on a day to day basis despite the presence of psychotic phenomena.

Additional reflections related to the person's own internal stigmatization of their mental health and how their interpretation of symptoms may link into self-esteem. This particular person did not want to give a name to their illness, and as time progressed, they were able to discuss how this was linked to not wanting to have a name for their difficulties as this would mean they are perceived as someone with a mental illness. In terms of self-esteem, it may be that paranoid delusions are directly related, with some people seeing themselves as the victim within their delusion, with it therefore functioning to protect their self-esteem. Others may see themselves as deserving of the content of their delusions and therefore present with low self-esteem. Given this person presented as more of the latter, it was important to consider that if delusions are an over-active mechanism to protect self-esteem, then caution must be used to prevent damaging this further when trying to normalise their experiences. [5]

The opportunity to work with a person through a course of CBT for psychosis allowed me to develop new thoughts and ideas, not only about CBT and its application, but also severe mental illness and how resilient people can be in the face of chronic and persistent symptoms.

Case 3

Having enjoyed completing a CBT case for generalised anxiety disorder (GAD) in my core training, I was keen to take on a further case in my higher training, not only to meet the Royal College's requirement, but also to further develop my skills in CBT. Despite feeling relatively confident in my ability to conduct CBT, accessing appropriate supervision and using resources to identify techniques, and in my ability to manage psychosis, I felt apprehensive when I was allocated someone with a chronic psychosis for my CBT case.

Throughout my training so far, I had little experience of working with someone in a relatively stable stage of their chronic mental illness, who's able to function at a high level whilst continuing to experience symptoms. I found it fascinating that through fluctuations in their ability to question their experiences, sometimes being convinced they were real and at others being unsure, outwardly there were no hindrances to them being able to go about their day-to-day life. This did however prove somewhat of a challenge in therapy as I was never sure what their response would be to tasks or questioning.

With regards to the therapy itself, I was pleasantly surprised about how quickly the individual and I fitted into the routine of CBT. Despite the problem being very different to my previous case, therapy had the same structure, similar tasks and we developed a strong working relationship. In the beginning of therapy, we came up with goals and, whilst on paper these may have read very differently to those for my GAD case, results soon felt attainable as it turns out that working with the distress caused by delusions isn't that different to working with hypothetical worries. When I consider the differences between my cases, the first thing that comes to mind is the slower pace of CBT for psychosis. We spent several weeks in the beginning stage of therapy to enable me to develop a real understanding of their experiences, and for them to be able to start linking aspects of their life and presentation together.

As with my colleagues, one of the main techniques that we used throughout the course of therapy was the development of a timeline of the individual's life as advocated by Marland et al. [6] We started this in session one when going over their history and we proceeded to add to it each week, eventually being able to link the way in which they were thinking, feeling and behaving to things that they had experienced in their past. In one session toward the end of therapy, they said their life had previously felt chaotic, however through doing the timeline things had started to make more sense.

Through working with this person, I feel I have a much better understanding of what it's like to live with chronic psychosis. I feel that this case forced me to question my own perceptions of psychosis and has allowed me to look at it in a different manner which has led to changes in how I work with these patients in all settings.

Conclusion

Each of the trainees found working with someone with psychosis for their CBT case to be a rewarding venture which not only enabled them to develop skills in delivering CBT, but also increased their awareness of individual experiences of living with psychosis. The trainees all felt anxiety about starting their cases, however they promptly discovered that the principles of CBT were the same for psychosis as for any other condition.

The rich understanding that the trainees developed of what it is like to live with psychosis was unique in their training thus far. One of the common techniques used in all three cases that helped with this was the development of a life timeline. This also helped those receiving therapy make sense of their lives and experiences in a way that they hadn't before and the trainees were able to tether ways the person thought, felt or behaved in the present to previous life experiences, further building on this understanding.

The learning through these cases has also extended into other areas of each of the trainee's practice, whether this be through their appreciation of personal experiences of psychosis, or through CBT techniques that they are able to embed into routine clinical work.

These experiences demonstrate that it is possible for trainees to successfully work with people with psychosis for their CBT case. Through doing so, they can meet the curriculum requirements for psychotherapy, develop their individual understanding of living with psychosis, develop knowledge of the models used in its delivery and, in line with NICE guidance, support services to increasingly offer CBT to people with schizophrenia.

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Poetry/Art contributions

A State of Mind

Prateek Varshney, MBBS, MD Psychiatry
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Sometimes I feel entrapped,
My mind is playing tricks on me from which I cannot snap,
I feel heavy and start to sink,
Gravity pulling me down and I am on the brink,
Things around me seem torrid,
At that time, I want you to be my rock, solid
Because I need that atom of hope
and our bond keeps us closer,
I matter, we all matter.

Sometimes I feel I am just going with the flow,
Will I boil over or simmer down?
A flood of emotions overwhelming me,
To be or to not to be.
Things around me seem hopeless and tepid,
At that time, I want you to be my elixir, life’s liquid,
Because I need that atom of hope
and our bond keeps us closer,
I matter, we all matter.

Sometimes I am surrounded by difficulties,
The room is full but I am lonely,
I drift away into oblivion slowly,
I gasp for air but I cannot breathe.
I bloat, I gloat and I feel a choking sensation in my throat,
At that time, I want you to wind the fire to help me float.
Because I need that atom of hope
and our bond keeps us closer,
I matter, we all matter.

When I am in a blissful state of mind,
I smile and beam with joy,
As this chain reaction starts with us being kind,
And I pass it on,
My potentials I harness and realize,
At that time a change I can catalyze,
Because I am that atom of hope,
and our bond keeps us closer,
You matter, we all matter.

Lights, Camera, Action

Aisha Duale, CT1
CT1 in Psychiatry, LLAMS, Harry Blackman House, Black Country Healthcare NHS Foundation Trust

I have a disorder, they say
My personality is disordered, untamed
I am unnamed, unloved, unheard
Absurd, I hear them say
She's moving in again, today
My home in disarray
My mind the protagonist in this play
Another pill to keep me at bay
Well, okay

Will the curtain not close
Will the audience draw near
Will my role ever develop
Or is this my forever career

Surrounded by uniforms and uniformity
Control movements and expression
The silence here births screaming
My brain settles though bleeding
So I bang and I bang, ready to wake into meaning
Wake into feeling
Run from the dreaming and pleading
Another pill for the grieving

Well, okay

Will the curtain not close
Will the audience draw near
Will my role every develop
Or is this my forever career

She’s a class act, they say
She’s a regular, this stray
Discharge, disregard, handover
Back to my bricks without soul
Back to my costumes without role
The applause absent, absconded
I ponder, what is the purpose of living in broken
Another pill for the notion
Well, okay

Will the curtain not close
Will the audience draw near
Will my role ever develop
Or is this my forever career

Psychotherapy

Kainat Khan, CT3
Essex Partnership University NHS Foundation Trust

Psychotherapy is form of talking therapy,
You do not have to say much necessarily
You rather offer it as your wonderings,
Listen attentively & be careful of your wordings
Keep in mind what other person is bringing,
They are there, for them to do the work of exploring
While doing it both will be learning,
Keep paying attention to patterns of relating

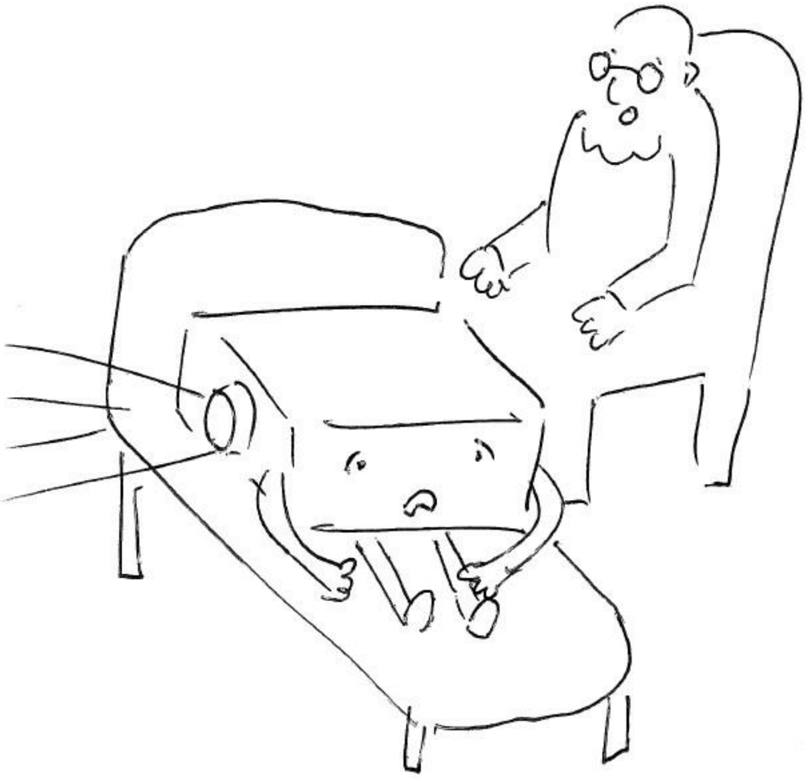
You bring your thoughts & ideas to supervisions,
You meet in team meetings and have discussions
You then realise how much was said with words unspoken,
Take it there is unconscious as your token
You cannot always predict how session will go,
What will play in the room or what will be to and fro?
Often than not they surprise with something new,
Bear the silences and speak words few

You are there to provide mental scaffolding,
Be the object containing and holding
However, do not ignore how you are feeling,
What emotions in you is this person stirring?
Use your transference and countertransference,
For feelings it generated, you might have some reference
Do not take words just on face value,
There is meaning beneath all that might be true
Take cues from what happen in room as it is all relational

Humans cannot be seen purely occupational
Remember at all times you must act professional,
So hold the frame, do not offer time additional
Work on therapeutic alliance
A lot of work basis will be on this reliance
So keep in mind, after all
Psychotherapy is form of talking therapy,
You do not have to say much necessarily.

Cartoon

Elias Diamantis
Dual Trainee, Medical Psychotherapy/General Adult, in Nottingham



"NOBODY LOOKS AT ME..."
"ARE YOU SURE YOU'RE NOT PROJECTING?.."

E.D
2022

Conferences

Organising the Trainees and Trainers Conference: Loss & Regeneration at the Freud Museum — highs, lows and lessons learnt

Chris Chan, Georgina Corbet-Burcher, Tom Dewhurst, Josie Fielding and Roberta Murphy,
STs across London

It was the summer of 2021 and the pandemic had been trundling on for well over a year. Covid lethargy was widespread, and trainees scattered across the country had resigned themselves to holding trainees' meetings via Zoom. The last Trainees & Trainers Conference was in 2019, and the Faculty Conference had just taken place remotely. This meant that some of us had only ever known each other as pixelated floating heads occasionally attached to upper torsos in small horizontal rectangles on a screen. There was a growing appetite to be together again, a longing to huddle with our fellow colleagues after the long and traumatic months we had survived, to embrace one another and talk together as whole bodies in a physical room together. And with the first vaccinations having gone round, hope was on the horizon.

So when the question came up again at the trainees’ meeting on that weekday evening in June, of whether a group of trainees might be interested in organising the next Trainees & Trainers Conference, one hand shot up confidently, followed tentatively by another, then another, and very soon, six of us found that we had formed a conference organising committee. With this initial task accomplished with surprising ease, the conference which had felt like a nebulous idea up until then quickly took form as a real entity, as enthusiasm and ideas on themes began to flow. What about a topical subject like gender or race? The climate? The effect of the pandemic on our clinical work? It was clear that possibilities were bountiful and there was plenty of work ahead.

Riding on the wave of enthusiasm generated by the formation of the committee, we organised ourselves with relative efficiency. Establishing a good time in the week when all of us could meet together regularly was no mean feat considering everyone’s work and in particular, personal analysis commitments, but thanks to WhatsApp, Doodle and the past year’s practice using Zoom, we established that remote meetings on Monday evenings would be best. Two weeks later, we convened as a committee for the first time, brimming with excitement and a little dazzled, curious to get to know each other and hopeful that whatever had brought us together would see us through.

So why had each of us raised our hand to join the committee? Some felt compelled to create something collective on the background of many months spent in relative isolation, for others it was about an opportunity to explore and understand their new identity as a medical psychotherapist amongst peers, whilst others relished the idea of having a platform on which to share speakers, thinkers and artists who interested and resonated with them. With some awareness of the mountain of work ahead, it helped to know that all of us were conveniently based in the same city, that in fact, four of us were in the same Trust together, and that some of us had also known each other through working together previously. It probably also helped that we all brought a wide range of academic interests and organisational experience, and that half of us had been involved in organising a conference in the past. Yet, perhaps the most important factors were our appreciation of how momentous and important it would feel to be able to have a Trainees & Trainers Conference again, and our commitment to executing the task at hand to the best of our ability. As with all well-functioning working groups, we were passionate about our shared vision, and determined to apply ourselves wholeheartedly to accomplishing it.

A realistic date for the conference was set for the end of February the following year, not too close and not too far away, not in a pre-ARCP period nor clashing with the Faculty conference usually held in April, nor any of the main holiday periods. We all had a yearning for it to be an in-person conference, although at that point, the logistics of ensuring the safety of a large gathering of people felt like a complete minefield. In the weeks that followed, we generated many ideas on themes we felt strongly about and then finally agreed on the theme ‘Loss and Regeneration’, which we felt encompassed the gravity of losses that had been experienced on a collective and personal scale, whilst also paving the way for the road ahead with a sense of balanced optimism.

We were very keen to have a mixture of presentation styles, not just lectures but also dialogues and panels, and also to invite speakers from a variety fields and backgrounds, such as writers, philosophers and artists, in addition to medical psychotherapists. Our passion and belief in the conference led us to aim high with speakers, not feeling afraid to contact eminent people who we thought could expound our theme, share fascinating thoughts and generate stimulating discussion. It must be said that the first responses to our speaker invitations were incredibly heartening and encouraging, a couple even heartily invited us to meet for tea and discussion - but there were also a few who sadly did not respond, so that we had to continually revisit our ideas and keep digging deeper for more. There were many repeated and painful refinements throughout this process in order to establish an adequately stimulating programme that was well balanced yet fitted into the time that we had, as well as suiting each speaker’s other commitments, and achieving this was immensely satisfying!

There were many other highlights. The few times that the committee were able to get together in person were oases of great social fun amidst our otherwise relatively focused labours over Zoom. We spent an enjoyable evening having dinner and drinks together on the Southbank and lunch on a weekend in one of our homes where each brought a dish of their own proud creation. On other occasions, when there was work to be done of a more excursive nature, we coupled up into pairs, for example to meet together to expand on ideas with a particular speaker or to scout for an evening venue. Needless to say, weaving these lighter social aspects into the process uplifted the organising process massively, in addition to allowing us more space for the fundamental task of getting to know each other more closely.

There were certainly also many challenges to navigate. The smoothness of the initial leg of the journey could not have predicted that Covid would continue to plague us with further mutations and social restrictions, and that the sense of uncertainty which had defined the past year would continue to cast its tiresome shadow over the long road ahead. One of our committee members gracefully bowed out, thus our committee of six dwindled down to five. One of the main difficulties was that although the previous 2019 conference had generated profit, we had no access to those funds which meant that we were asking our speakers to provide a free service. Later on, the Faculty’s substantial financial gift did lift this weight.

The lowest moment by far was when after nearly half a year of consistent hard work, December 2021 came round with a new Covid strain and the possibility of further lockdowns. Should we press ahead? Could we? With government rules often in conflict with NHS guidelines, which rules ought we be guided by? The committee was split on these questions and consensus evaded us until it became clear that the only way we could proceed with going ahead with our conference in February would be to hold it remotely, which we all felt deeply reluctant to do. Yet, who was to say that even if we were to postpone the date of the conference, we would be able to hold the conference in person? There were many questions and no guaranteed answers. Often, as in our clinical work, there are no right or wrong decisions, and finally, we made the best one we could, albeit with heavy hearts: we decided to postpone the date of the conference.

Thankfully, even though this brought multiple fresh complications, our deliberations proved worthwhile. When the new date of the conference arrived, the 25th of May, the sun shone bright and fresh spring flowers in bloom danced merrily in Freud’s old garden. The long-awaited day had arrived after nearly a year’s work and our spirits were high, together with all manners of anxieties about whether the day would run smoothly. However, our worries proved unnecessary. From the moment the first delegates came through the sky-blue door of Freud’s old London home, to the moment that the same door closed behind us at the end of the day, all that had been planned unfolded with a steady rhythm of its own, propelled by the warmth and delight of everyone present, nourished by being together again. It was a day full of heartwarming moments, stimulating thought and touching, rich exchanges amongst good company. It was all we had hoped and worked for, and more. The evening get together at a nearby pub was a cheerful and celebratory affair, and truly, we felt we had done ourselves proud.

In the weeks and months since that memorable day, we have become increasingly aware of the need to hand on the baton to the next group of trainees who will form the next conference organising committee. So we have been asking ourselves, what do we wish we had known at the start of our organisation process, and what do we think helped? Many of the factors seemed serendipitous and outside the remit of our control, such as the caliber of the speakers and enthusiasm of everyone present. However, we thought that perhaps the following list of 10 things, some of which had been helpfully handed over from the previous committee, might be helpful to pass forward like a message in a bottle flung out into the open seas.

1. **Decide how to work together** as a committee e.g. would there be a leader and clear roles assigned to each person? We decided on a more egalitarian structure where all voices were given equal importance, and where decision-making was shared amongst the group. This meant that roles and responsibilities were more fluid and were worked out as we went along.

2. **Optimise the diverse qualities** within the committee in accordance with each person's particular strengths, skill set and talent. In our group, those more inclined towards mathematics took on a budgeting role, those with artistic talents were in charge of designing the artwork, some were more naturally attentive to the finer details and others to the overall concept of the day. Similarly, on the day itself, tasks were assigned according to choice and skills, with a willingness to flex into different roles and help each other out throughout. We also accommodated the unique circumstances of each person, as some were less able to consistently attend the regular evening meetings but were able to catch up and attend to jobs and tasks via the minutes we kept.

3. It **does take some stamina** to see the process through its ups and downs. Hopefully, this article has demonstrated that many unforeseen challenges may unexpectedly arise and at times, we held meetings as often as weekly when necessary – and at other times, more infrequently, but this can take some toll in addition to the other responsibilities and commitments of the group.

4. Remember to **set aside time and space for reflection**, both within the organising team and in the conference programme itself. Often, during our meetings, we would check in with how we were feeling rather than staying narrowly focused on practicalities, but we expect that this will probably come quite naturally with any group of psychotherapy trainees coming together! As with any group under considerable pressure, we were subject to unconscious processes such as splitting, pairing and fight/flight at times and it helps to have time, space and they will work these through.

5. It takes a **considerable amount of funds** to put on a conference and it helps to have something in reserve for initial down payments. The Faculty were very generous with this conference but remember that one does not get without asking.

6. Decide on the **theme, venue and general structure** of the conference early on. Will there be mainly lectures or a mixture of delivery styles? Would there also be the option of joining in remotely e.g. a hybrid model which seems increasingly popular? For example, having decided on the theme of the conference, we felt that a venue with access to natural outdoor spaces would be preferable to a building that felt more sterile and clinical.

7. Consider **catering, food and refreshment** options carefully as these are key elements that bring delegates together, and a big part of the budget. We felt that ethical and healthy choices were important and engaged a plant-based women's refugees 'catering company, as well as deciding against having any artificially flavoured soft drinks.

8. **Do not worry about ticket sales**, particularly early on. Many delegates seem to leave it right up to the wire before getting their tickets and we went quickly from worrying about not selling enough tickets to completely selling out and people contacting us right up to the day of the conference to ask if they could be squeezed in.

9. Consider obtaining **formal CPD-accreditation** for the conference as this would likely draw more consultants and trainers. We did not do this but wish we had thought to explore it earlier on.

10. Last but not least, **enjoy the whole process and especially the day** itself, all the highs and the lows, taking time to pause within the day itself to reflect on and appreciate the creation!

As a final thought, the conception, birth and parenting of a big project like this can surprise one with the depth and range of profound and complicated feelings that arise: immense pride over each accomplishment; painful disappointment with each perceived failure; an overarching sense of protectiveness that can unexpectedly activate one's frustration and aggression; intense anxieties about not being 'good enough' parents; and finally, sadness in mourning the loss of our 'baby' but also much joy and anticipation at its regeneration in the hands of a new organising committee.

There is No Regeneration Without Loss

Alina Braicu
Dual ST5 in Medical Psychotherapy/ Gen Adult Psychiatry
Birmingham and Solihull Mental Health Foundation Trust

Loss and Regeneration was the perfect theme for the first Medical Psychotherapy trainers-trainees face to face conference for 3 years, due to the Covid pandemic. I was excited to attend this conference again, especially at such a great venue. I had attended a conference before at the Freud Museum five years ago, but I did not have the time then to properly immerse myself in the atmosphere and take the time to look around. When I arrived, the garden of the museum was welcoming, and the roses and elderflower were in blossom. Their scent reminded me of my childhood, when I would pick these flowers so that my grandmother could prepare a delicious elderflower juice with fresh honey and squeezed lemons. For a moment I forgot I was Freud's 'guest' and that I was there for something else.

One of the speakers was Dr Marchelle Farrell, a gardener, a writer and a medical psychotherapist. She read an excerpt from her book which talked about the relationship between our external landscapes and the internal ones, how the land, and particularly her garden, helped her to understand herself.

Dr Joseph Dodds' perspective was quite different. He was talking about how psychoanalysis can offer important insights in the problem of current climate change and its effects. Joseph brought into the discussion the role that *joy* plays in this crisis and how, by bringing people together, it can be a useful tool we can use to fight against our extinction.

I felt inspired by hearing about Dr Adrian Hayes' therapeutic community-informed group. How interesting for patients to play a more active role in this group, and use a more flexible group approach! One member of the group explained how she felt that she was given a voice in her experience and her relationship with the diagnosis of personality disorder. One doesn't hear too often that patients are given a voice, especially by their doctor.

The three parallel workshops had interesting themes: Social Dreaming, a Drawing Workshop and a viewing of 'Perspectives on Visibility'. I chose the latter because its title made me curious - how a VIP (Visually Impaired Performance Artist) challenges "the seeing eye" thorough her cabaret with drag performance.

This conference was very welcomed, particularly by medical psychotherapy trainees. Prompted by Marchelle's reflection on her professional non-linear trajectory, from medical school to higher training and then consultancy, we also reflected in the large group: where is the hurry to become a consultant psychotherapist? Will we be prepared for this role in just a few years' time? It is okay if life, people, and landscapes can sometimes take us outside of the established trajectory.

Since joining the Higher Training scheme, I had already met some of the medical psychotherapy trainee colleagues on our WhatsApp group and in the zoom meetings. And today was better than I expected. I felt I was talking with friends I have known for many years. Not surprisingly, the main theme was the impact the pandemic had on our jobs, family life, on our training in general. We all have been affected by the loss the pandemic brought into our lives but concluded that *there is* ***no regeneration without loss****.*

The Community of Communities Forum: A sense of… Community!

Rebecca Perry CT3
Leicestershire Partnership NHS Trust

I always find rotation list reveal days a bit nerve wracking, unsure if I've got one of my top choices, excited (and trepidatious) to see who my supervisor is! I remember being so pleased when I was allocated a six-month placement at Francis Dixon Lodge, a Therapeutic Community in Leicester that has been running since the 1970s. I'd been requesting it as my top choice each application as it was the psychotherapy placement, the holy grail of rotations, which I was relying on to decide if psychotherapy is the way forward for my career, finally it was here. Now I just had to work out what was going on… (luckily, I was joining an extremely kind and knowledgeable team).

So what are Therapeutic Communities (TCs)?

The Consortium for Therapeutic Communities defines them as *"structured, psychologically informed environments – they are places where the social relationships, structure of the day and different activities together are all deliberately designed to help people's health and well-being."* Honestly, I think TCs are hard to define in writing, they are so varied, from residential children's homes to 24/7 prison placements to our 2 day a week MBT based therapy program (which at time of writing is on Teams, though soon to return to being in person). The best way to understand them is to experience them; if you are able to, I would highly recommend trying to arrange to visit one. Despite how different they may look, TCs hold a shared set of values and a culture that is deeply important, a living and learning therapeutic experience, with shared meals and responsibilities- from taking minutes to hoovering. Many TCs are members of the Community of Communities, an accreditation program which uses visits and reviews to ensure that the principles and standards are being upheld - democracy, tolerance and safety are 3 of the 10 core principals. [1]

Community of communities forum

The Community of Communities hosts an annual forum which, like most things, has been disrupted by COVID. This was its first year back in person at the RCPsych London offices and the theme was 'TCs in Transition'. Previously our TC has taken collective trips down, with both staff and patient members going. Unfortunately, this year we could only facilitate 2 staff members attending, as a new staff member I was grateful to be going with Mark Bird, TC manager who's worked in the service for several years. After planning with the patient members, the decision was to record an MS Teams session. The whole TC spent one session collaboratively coming up with questions to prompt discussion and then the next one having an open but structured conversation. This was recorded and Mark and I presented it at the conference. We covered topics such as how it felt with TC moving online, adopting the MBT model and what being a member of a TC means to them. It was an engaging and interesting conversation with people expressing their different views and experiences.

The day started off at 5.30am, which in my view is unacceptably early, but travelling from Leicester to central London for a 9.30am start involves some sacrifices! Returning to the

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[1] https://therapeuticcommunities.org/about-us/tc-core-values/

RCPsych building on Prescot street definitely added to my nerves as I remembered very clearly sitting Paper A there several years prior, which is not a cherished memory. Thankfully we arrived on time, I was not expected to sit an exam, and all the technology tests went ahead with no hiccups. After the introductory speeches it became clear that the C of C's forum would be quite different from the usual medical conference- chairs were arranged in a giant circle and a community meeting was held. The same community meetings that we hold in our TC were echoed in the large auditorium. People shared their thoughts, feelings, fears and hopes for the day, year and their TCs which was amazing to experience.

As the workshops started, I was so glad to be presenting something that I truly felt represented our TC and the voices of the members. It was wonderful to see a room full of attendees really engage with what we shared. Although the majority of the presentation was in video format, I think that the past 2 years of doing online therapy has shown us that powerful emotions can still be communicated even if they are shared by people who are not physically in the room with us. The experiences that our TC members spoke about resonated with a lot of the audience that day and the discussion after the video was full of gratitude and solidarity. In the hopes of trying to capture some of that and bring it back to our TC, we asked the attendees to write some feedback, which contained a section 'What would you like to say to the members who couldn't join us today?'. We have taken the time since to share that feedback with the members and talk about our experience of the day, which was really well received.

The day didn't end there. We attended a workshop about a very different TC, a residential boys' home, and learning about the impact their work has on the children in their care was amazing, especially as I had previously been unaware how many TCs there are for children. The afternoon saw more people sharing their lived experience with a group acting out the internal monologue that changed throughout their journey of being in a TC - a story full of hope and vitality that really inspired me. On a more practical note, the description of their processes for leaving the TC was really useful as it's an area of our service that is currently being redesigned so we relished the opportunity to make contacts and learn from the practice of others.

The keynote speaker, Fakhry Davids, gave an important, meaningful, and thought-provoking speech about racism. Drawing on his experience of training in South Africa during apartheid and seeing how racism manifests in therapy, he explained his psychoanalytic approach, termed internal racism. The forum wrapped up with a second community meeting, one which felt reflective and sincere. Talk of loss and transitions was prevalent, as was hope for the future and the continuation the of important work that TC's do.

Reflections

The whole experience was very powerful. I felt inspired by what everyone shared, both staff members and those with lived experience. Getting to see the impact our members' voices had on the attendees was a real privilege; the feedback we received was heartfelt and meaningful. The themes that came out were the same as the ones that I felt regarding my experience of the day - being thankful for the people who were brave enough to share their stories, that hearing them was very powerful and that community is vitally important. Although I will be moving on from my placement in the TC in August, I feel it has had a large impact on my practice as a psychiatrist. It has made me understand the deep importance of coming alongside our patients and truly listening to their experiences. I hope to return to both TC work and the Community of Communities Forum in the future.

Book/ Article Reviews

Editors: Dan Beales
The Iris Centre, Devon Partnership NHS Trust
Andrew Shepherd
Greater Manchester NHS Mental Health Foundation Trust/ University of Manchester

The Ailment – a reflection

Giancarlo Novani
NHS Greater Glasgow & Clyde

A while back I presented a case at Balint group where I'd assessed an admitted patient who wished to leave the ward and essentially concluded they were not psychotic. Instead I theorised their behaviour was that of someone simply trying to arouse particular emotions from the staff. I arrived at this juncture with a bit of pressure from the nursing team who made it very clear prior to me meeting her, they felt she was "putting it on." Rather than wipe the mental slate clean, assess her impartially and make my own mind up, my sight was tinged with the tone of their dislike for this patient as I entered the room. I didn't fully realise this at the time, and ended up capitulating to her request to leave, only for her to be re-admitted within 48 hours after getting herself arrested. In the end she was quite psychotic; it took a series of assessments to uncover the delusional system which made me feel less stupid. No major harm ensued as a consequence of my actions, so I quietly licked my wounds and timidly presented her alongside my damaged ego at the group. Our facilitator, honing in on the burden of the emotions of others, asked if I'd ever read "The Ailment" by Thomas Main. Until then I hadn't and this was the second Balint facilitator to recommend it. Helpless to resist, I went on the hunt for more insights.

Published in 1957, "The Ailment" is an account by Main of an experiment which attempted to unveil the root cause of copious amounts of sedation being used on particularly "difficult" patients, as well seeking to explain a number of staff burnouts relating to it - some of whom Main describes as skilled and experienced nurses. He did what Balint had done only a few years before: got those concerned together in a big group, got everyone to tell their stories of what happened leading up to the sedation of these particular patients and everybody hung their thoughts and feelings out to dry. Main himself said he was taken aback by the results after several months of weekly meetings. All involved were nurses bar Main, and it seems they were a rather courageous lot to divulge the depth of feeling that becomes apparent in the paper. No doctors participated to the same degree, the reasons for this are not known entirely, only theorised. The patients discussed totalled 9 in number. All were female – Main points out that roughly 2/3rds of inpatients were female at this time. Interestingly, 8 of the 9 were either doctors, doctors' secretaries or relatives of doctors and Main forms some theories as to how this might relate to their relative difficulty to treat.

Two things have really stuck with me from this, the main one (excuse the pun) being that patients make us feel things. It perhaps sounds stupid to write this in a reflection aimed at a Medical Psychotherapy publication, but after reading this it seems the weight of such a message thrusts into the jugular of something deeper than I had really given heed. Main teases out of the group that these patients made particular nurses feel superiorly empathetic compared to their peers. This led to a nurse feeling that she understood a patient more than the other staff, which in turn caused her to invest more special time in the patient, encourage more exemptions from hospital routine, and increase emotional investment in their recovery.

Rather than cure the patient, giving more simply paved the way for more demands to flow. When demands were not met, patients would threaten to abscond, threaten to self-harm, carry out self-harm or threaten suicide. Additionally, none appeared to have gotten any better despite the torrential efforts to soothe their psychic pain. One can easily see a vicious cycle crystallising where everybody loses. In the end, the group realise they had sedated the patients not to soothe them, but to gift themselves a reprieve from the suffering inflicted on them by the patients. As I mentioned, several staff were left utterly depleted and had to take extended leave. These are extreme examples, but they display the potential power of patient interactions and showcase its bi-directional nature.

I met my first patient in CAMHS recently. He was a 6-year-old boy who sat nicely and swung his legs rhythmically beneath the chair like two pendulums from a grandfather clock for the whole 45 minutes. I couldn't help but think of my eldest son, who is much younger, but has a real penchant for this also. No words entered my mind, just the idea of him was there - like an apparition. I felt love, and peace and then it was gone, I was back to the criteria for ADHD with the smouldering remnant of how I feel about my son behind it. Another example was in psychotherapy supervision: we discussed potential cases for another trainee's short case and one of the prospects is pregnant. I thought of my wife and my unborn child. I felt love, fear and immediately an instinct to shield this woman and give her additional empathy – as I do my own wife. Then it was gone. It could have been seconds, perhaps less, but it was there. All it takes is the same string of words you recall your father saying to you at a tender moment, or even somebody whose wrinkles vaguely match those on your ageing grandmother and suddenly there is a nerve-jerk reaction to a place in your mind. As a result, a cocktail of emotions and instincts are conjured which can be distracting, or quickly quieted. An imprint, however, is left on your emotional palate, be it deep space or so shallow it can barely be said to exist.

One might hope to suppress or prevent such unexpected mental events, but it's important for us to be emotional, to reciprocate, respond and empathise. How outward we are with it is another matter. These things probably go mostly unnoticed by patients and ourselves in day to day interactions. But they can be so powerful, so stealthy and subtly steer you in varying directions as your bash your assessment and management plan into the keyboard afterwards.

I am coming to be more aware of this in myself and there are a few big themes for me. I have to be careful to ensure my personhood doesn't leak too much into what is supposed to be an impartial encounter. There are things which drench me with disgust, fear, disdain and even shame. Trying to ensure you deliver care of equal quality unencumbered by bias (conscious or unconscious) to patients who fill you with dread or hopelessness is not easy. I think the best way to begin is to pay attention to those biases which surface from time to time. Reflect, talk, go to Balint group, and move forward one micro-epiphany at a time. It is a good practice. Uncomfortable but necessary – a bit like soft tissue massages.

I would go so far as to say that even the knowledge that you are about to encounter a patient begins to evoke emotion. Perhaps fear, curiosity, excitement or sadness if it's 4pm on a Friday. If you are doubtful, try my experiment the next time you know you are going to see a patient. Just read their name, nothing else. Take a moment and allow a silent picture to be painted in the mind's eye, then ask yourself what it made you feel. When I say take a moment, I mean take your time, really rake around in there because it's likely to be small, but it'll be there and the reactions which ensue will snowball as you then see them.

On a slightly different note, my GP trainer once asked me "How quickly do you think you know what you want to do with a patient after you start the appointment?" I said, "I don't know, within the first couple of minutes maybe?" He said "Maybe, but I'd say it's probably more like a few seconds." That made me think, a lot. About assumptions, about judgements, about agendas. It especially made me think about the power of what is already in our minds before we even start speaking to a patient, and how hard it can be to have a genuinely open mind when you don't know what is coming through the door. How hard will the patient be to contain? Will I find them or their issues disturbing? Can I do anything to help? Do I even need to do something? What if I can't do anything, how do I tell them?

There is so much to say about this paper, in particular about the select group of patients being put under the microscope. It's grim actually, how it pans out – nobody really gets better. Main describes the patients as "demanding of love, and torturing others into giving it to them." Torturing others, through "aggressive use of distress" as he puts it. It's interesting, the language is pretty unforgiving towards the patients, but the description of their presentation really brings to mind what we have come to term "borderline" or "emotionally unstable personality disorder." A rundown of all that would be good for another time, but there is no adequate alternative to simply sitting down with a generous cup of coffee, reading through his writings, lighting your pipe then reclining back and letting the micro-realisations flow.

Call for future book reviewers and contributions

We are looking for contributors and fellow bookworms to contribute reviews to the newsletter, as a guide around 800 - 1,000 words but this is flexible.

We are keen to hear from you if you have an idea for a review, want to share books you wouldn't do without/ classics revisited/ hidden gems; a series for discussion or other contributions to make.

We have made contact with a number of publishers in the field and are able to negotiate access to review copies in many cases. Please therefore, if this is something you are interested in helping to take forward, send an email to the Book review editors Dan Beales and Andrew Shepherd, via Catherine Langley.

Events, Notices and Dates for your Diary

European Psychoanalytic Film Festival 4-6/11/22

Dear Movie lovers,

You are warmly invited to the eleventh European Psychoanalytic Film Festival on 4-6/11/22!

I have managed to secure a special deal for trainees 2 for 1

Here is the link for trainees:
https://psychoanalysis.org.uk/civicrm/event/info?reset=1&id=1320

There are also group tickets available to purchase, (to qualify as a group it will need to include a minimum of 5 people that want to book together)
- tickets are £155 each - please contact: outreach@iopa.org.uk

This is the link to the programme and online magazine:

https://psychoanalysis.org.uk/civicrm/event/info%3Fid%3D1179%26reset%3D1

The theme is 'hope' and I hope to see you there!

Very best wishes

Dr Anne Patterson, co-director of epff 11 and scheme psychotherapy tutor NW London psychiatric training schemes

RCPsych Library - Medical Psychotherapy Faculty Newsletter

Need access to online journals and other resources?
The College Library provides a wide range of library services to members, primarily OpenAthens accounts to help you access research online.
The collection is built on member recommendations, so if you can't find something you need, just let us know and we can look into adding it to the collections.
Databases – the College provides access for members to Medline, PsychINFO and Embase.

Journals – some examples include: Lancet Psychiatry, the American Journal of Psychiatry and European Psychiatry.
Books - We have a physical library and members are welcome to borrow books, which we will send out in the post for free. We also provide access to online versions of the **BNF** and the **Maudsley Prescribing Guidelines**.

For any articles not available through our own subscriptions, we offer inter-library loans, finding what you need in another library and sending it out to you by email.

We also offer a free and unlimited literature searching service for those who do not have the time or confidence to search through the medical databases. This can also be combined with training for anyone who wants to refresh their skills.
You can find all these resources on the College website:
www.rcpsych.ac.uk/library
Or get in touch with us directly:
infoservices@rcpsych.ac.uk
020 8618 4099

Best wishes,

Fiona Watson
College Librarian

Medical Psychotherapy Faculty Annual Conference, April 17th – 19th

We are excited to announce the dates of the next in person **Medical Psychotherapy Faculty Annual Conference, April 17th – 19th**, entitled **"Can the current global crisis bring us all together?"**. This conference will be held in person at the College. The 2nd winner of our annual Medical Student essay prize (which was launched last year) will be announced, as well as the trainee poster prize. The details of both of these prizes are on the college website. Please save the date!

Psychodynamic Psychiatry day

We are looking forward to the forthcoming **Psychodynamic Psychiatry day** taking place on **11th November** this year which is on the fascinating topic of Psychodynamic aspects of Psychedelic assisted therapy. This is taking place in person at the college but will also be live streamed and should prove to be a stimulating and informative day.

2023 Trainees' conference

Trainee reps are at work planning the 2023 conference, which will be held in Birmingham. This will be a unique collaboration between medical psychotherapy trainees and psychART (https://www.psychart.org.uk/), a trainee-led initiative exploring psychiatry and the arts. Do keep an eye out for further updates on the conference – if you'd like to register your interest in advance, please email the conference committee on: mptrainertrainee@gmail.com.

Faculty group

The group for consultants and higher trainees in Medical Psychotherapy continues to meet on the last Thursday of the month at 5.30-7pm. If you would like to join, please contact Catherine Langley so that your email address can be passed to Mark Morris.

College conferences

College conferences and events can be viewed at Conferences and training events | Royal College of Psychiatrists (rcpsych.ac.uk)

Call for submissions

Many thanks to all who have contributed to this newsletter. Please continue to send in contributions over the next few months for the spring edition. The deadline for submissions is **17th February 2023.**

All contributions can be sent to me or to sub-editors c/o Catherine Langley at Catherine.Langley@rcpsych.ac.uk.