

**Autumn/ Winter 2024**

**In this edition:**

**Reflections on spirituality and aesthetics  
Power, conflict and leadership in the NHS  
Climate and social justice  
Trainee voices**

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## Editor's Welcome

**Dr Pamela Peters**

Consultant Psychiatrist in Medical Psychotherapy, Cambridge and Peterborough Foundation Trust



It is autumn/ winter again and as we head into darker and colder days, time to reflect on the passing of another year. This one has felt difficult and chaotic with calamitous events the world over – wars; the effects of the climate emergency becoming ever more acute and obvious; political upheaval; and locally, ongoing limitations in resource affecting the treatment and care we offer to patients in the NHS, as well as our own wellbeing, whilst mental health difficulties reach new heights of frequency and acuity.

Coming back to the relational focus feels like the best way to maintain one's sanity – with patients, colleagues, friends, in organisations and in communities. Every now and then I become aware of different community-based movements that are taking forward particular ways of thinking and interacting with the world that are different from the mainstream and challenge its assumptions – from mending items rather than throwing them away, to groups of artists and writers coming together to think and share new ideas. Some of these groups transcend national boundaries.

I read an article the other day by Lord John Alderdice, who spoke at our Faculty conference this year, and who takes the long view in "Beyond reason", <https://analytic-room.com/essays/beyond-reason-by-john-alderdice/> stating that the crises of our times create an inflection point where we have an opportunity for a paradigm shift in how we configure social structures. Analysis of complex networks of relationships can help us reach solutions with entrenched problems e.g. the work that led to the Good Friday agreement.

Compiling this edition of the newsletter took me on a journey through NHS history, and led to reflections on spirituality and aesthetic moments, as well as a recognition of the variety of work that people are doing – a strand running through all this is the need to be creative rather than process-bound, to free ourselves to think and feel together with our patients and colleagues. It is clear that there is plenty of this going on, if we look for it.

Thank you to all of you whose contributions make this newsletter – your voices are very much appreciated. Please keep sending in your articles, reviews, poetry and art – the deadline for the next edition is 14<sup>th</sup> February 2025.



## Message from the Faculty Chair

**Dr Jo O'Reilly**

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



Welcome to the Medical Psychotherapy Faculty Autumn/ Winter Newsletter.

Thank you as ever to the editor Pamela Peters for putting together such an interesting and stimulating collection of articles.

The Medical Psychotherapy Faculty Executive Committee meets three times a year and we had as usual a full agenda for our meeting in October. I am now over half-way through the 4-year role as Faculty Chair and am very pleased that the faculty has become so active and contributed to so many important projects and workstreams at the College. These include working closely with other colleagues/ faculties on areas of shared interest, such as the ongoing push to reinstate the central roles of psychotherapeutic relationships and holistic biopsychosocial formulation across mental health care. We are very involved in college-wide activities including a working group addressing prejudice and discrimination in people who receive a diagnosis of personality disorder, and are leading on developing an RCPsych position statement supporting reflective practice as an essential activity for all staff.

A position statement jointly written with the Psychopharmacology Committee on the potential therapeutic use of Psychedelic and Related Substances and a second Guidance document on Good Therapeutic Practice when working with these substances produced from a Medical Psychotherapy Working Group are due to be published by the College shortly. I hope we are increasingly seen as a specialism able to contribute to the psychological understanding and psychotherapeutic aspects of the work for all of psychiatry, as well as advocating for and delivering a broad range of psychological therapies to meet the diverse needs of our patients.

It's great to see the renewed interest in the importance of clinical relationships in containing distress and supporting recovery across psychiatry. But as we all know relationships are rarely comfortable or easy, especially if someone has experienced harmful relationships when in need of care and support at other times in their lives. The Psychodynamic Psychiatry Day on 1<sup>st</sup> November 2024 delved into the intricacies of the patient-clinician relationship and its potential both for developing a shared understanding and growth, but also for repetition of destructive dynamics and iatrogenic harm. Titled "Trouble in Mind: Yours or Mine? The Location of Disturbance in the patient-clinician relationship", it was a very moving experience to think together about the "patient" parts of us all - and the resources and insights within us, whether carrying the role of patient or doctor in clinical encounters. Developments are under way for the 2025 Medical Psychotherapy Faculty annual conference which will be at the RCPsych in London from **30<sup>th</sup> April – 2<sup>nd</sup> May 2025**. This conference will further explore themes of

relationships within wider societal and cultural contexts, with a focus upon themes of inclusion and exclusion and we hope to see many of you there.

Our bi-termly on-line seminar series for all members of the Medical Psychotherapy Faculty have been a great success and become rapidly booked up. Thank you to Rachel Gibbons and Vikram Luthra for developing this. And many congratulations to Swapna Kongara, Millie Tamworth and Rachel for an excellent piece of research and publication: Experiences and support needs of psychiatrists under investigation. *BJPsych Bulletin*. <https://doi.org/10.1192/bjb.2024.80>

And lastly, I am delighted to let you know that Rachel Gibbons, Vice Chair of the Medical Psychotherapy Faculty has been recognised for her outstanding contributions to psychiatry and has been awarded a Royal College of Psychiatrists President's medal. Rachel is trained as a general adult psychiatrist, medical psychotherapist, psychoanalyst and group analyst and draws upon her breadth and depth of training and experience to go into some of the most painful and controversial areas of our work with courage and creativity; we are lucky to have her.

Wishing you all a very enjoyable read and hope many more of you will continue to contribute to future newsletters and join us at our conferences and events.

## Update from the Academic Secretaries

**Dr Parveen Bains**

Consultant Psychiatrist in Medical Psychotherapy, Hertfordshire

**Dr Sophie Atwood**

Consultant Psychiatrist in Medical Psychotherapy, Sussex

**Dr Vikram Luthra**

Consultant Psychiatrist in Medical Psychotherapy and Psychoanalyst, Leeds

**Dr Anne Cooper**

Consultant Psychiatrist in Medical Psychotherapy, Leeds

Greetings from the academic secretaries – it has been a busy year of successful and well attended conferences and study days, and we are very pleased to highlight some upcoming events:



### Medical Psychotherapy Annual Faculty Conference, Wednesday 30<sup>th</sup> April to Friday 2<sup>nd</sup> May 2025

Following the success of this year's conference in Leeds, we will be returning to the College in London for the 2025 Annual Medical Psychotherapy Faculty Conference. The theme for the conference is: **Inclusivity/Exclusivity: Medical Psychotherapy, labels and stigma** which we hope will be relevant for everyone.

#### Some of the highlights of the programme include:

Wednesday 30<sup>th</sup> April - Dr Jo O'Reilly (our Faculty Chair) in conversation with Horatio Clare and Professor Femi Oyebode to consider, *Is Psychiatry working? What is the place of psychotherapy in psychiatry?* This conversation follows on from Horatio Clare and Professor Femi Oyebode's Radio 4 series 'Is Psychiatry working?', and Horatio Clare's writing, including his book 'Heavy Light', considering his own lived experience.

Thursday 1<sup>st</sup> May will begin with Dr Rachel Gibbons (Vice-Chair of the Faculty) in discussion with Dr Lade Smith (President of the College), followed by a talk by Dr Dan Beales (Consultant in Medical and Forensic Psychotherapy) entitled *Dead or Alive - Is diagnosis relevant for Medical Psychotherapy?* There will be talks on *Racism* (by Dr Cissy Atwine) and *Psychotherapy and Sexuality* (Dr Graeme Whitfield).

On Friday 2<sup>nd</sup> May we will host a panel session on *the development of the RCPsych position statement on the impact of non-recent child sexual abuse on mental health* led by Dr Jo Stubley and Dr Maria Eyres. This will be followed by talks on *CBT for Complex PTSD* and *Personality Disorder and stigma*. On Friday afternoon we will announce the winners of our poster presentation prize and the medical student essay prize, the title of which will reflect the theme of the conference.

We are delighted that Dr Maria Papanastassiou and Dr Diana Menzies will be returning to facilitate the experiential groups on Thursday and Friday.

Registration for the event is now open and we hope you will join us for a thought-provoking and stimulating event.



[Faculty of Medical Psychotherapy Annual Conference 2025  
- Inclusivity/Exclusivity, Medical Psychotherapy, labels and stigma](https://www.rcpsych.ac.uk/conference2025)

[www.rcpsych.ac.uk](https://www.rcpsych.ac.uk)

### Medical Psychotherapy seminar series talks

This well-attended series has ended for 2024, with the last talk taking place on Thursday 21st November. Dr Miriam Barrett and her team at the Cassel Unit discussed **Therapeutic Community Treatment for Patients with Complex Emotional Needs**. These events are free, and spaces are allocated on a first come, first served basis.

We would be grateful if you could email Vikram Luthra ([vluthra@nhs.net](mailto:vluthra@nhs.net)) if you have attended any of the seminar series talks this year and are able to provide feedback on the events and anything that you would like to see more of next year.

## Trainee Reps

**Dr Toby Stevens and  
Dr Elias Diamantis**

A warm welcome to all those who have started their training this year, we hope you are settling in and enjoying it so far.

As reps, we continue to work closely with the Faculty to address issues raised by trainees – if there are issues concerning your training that can't be addressed locally, or you'd like to get more involved, please do get in touch with us at [mptrainerep@gmail.com](mailto:mptrainerep@gmail.com).

We also have an active WhatsApp group for trainees to share news and ideas. To be added to this please email us on [mptrainerep@gmail.com](mailto:mptrainerep@gmail.com).



## Feature Articles

### Reflection on writing 'The Spirit of Psychotherapy: A Hidden Dimension' (Karnac 2024)

**Dr Jeremy Holmes MD FRCPsych**

Former Chair, Medical Psychotherapy Faculty & Honorary Professor, University of Exeter

There are certain distinct *pause points* in a person's life: in a dark wood (ask Dante), the menopause (clearly), and the andropause (possibly). For therapists, let's postulate a 'philosophopause' - a moment, as things draw to a close, where one asks oneself 'what the hell have I been doing all these years?'.

Anyway, that's what happened to me when, retired from the NHS, and, as the politicians put it, wanting to 'spend more time with my family', I decided to zoom out from everyday practice and think about what psychotherapy really is, why it matters, and how it fits into western cultural life.

My starting point was the banal aperçu that psychotherapy has replaced a place in society previously occupied by religion. I began to think of the consulting room as a *sacred space*, where the normal rules and conventions are held in abeyance, much as was the case with churches and cathedrals. I wanted to move beyond my beloved focus on evidence-based practice, secure attachment, transference interpretations, etc, to what's really going on when we sit, listen and converse with our patients.

I homed in on what I call the hidden dimension, that is, *praxis*. Now, praxis is a difficult word: it takes us beyond theory to what we actually *do* with our clients in the immediate here-and-now – the body and its persona we bring into the room, our history, our own struggles and traumas, our demographic profile and above all, our inner world and its creativity. Familiar territory for followers of Marion Millner, but little discussed in the psychoanalytic literature. I wanted to explore this existential present moment of the therapeutic encounter, and its contribution to contemporary culture.

Pursuing the religious parallel, I began to conceptualise psychotherapy as a species of *secular spirituality* in a world of utilitarian disenchantment. I decided to interview a sample of religious people from a variety of faith backgrounds: Druidic, Buddhist, Muslim, Daoist, Judaic, Christian fundamentalist and Quaker. The most striking finding was, despite marked differences in 'beliefs', how similar were the experiences interviewees described as positively religious or spiritual. These included a sense of awe, being part of a community, finding an overall framework in which they felt accepted and validated, and moving beyond self-preoccupation to a wider sense of connectedness.

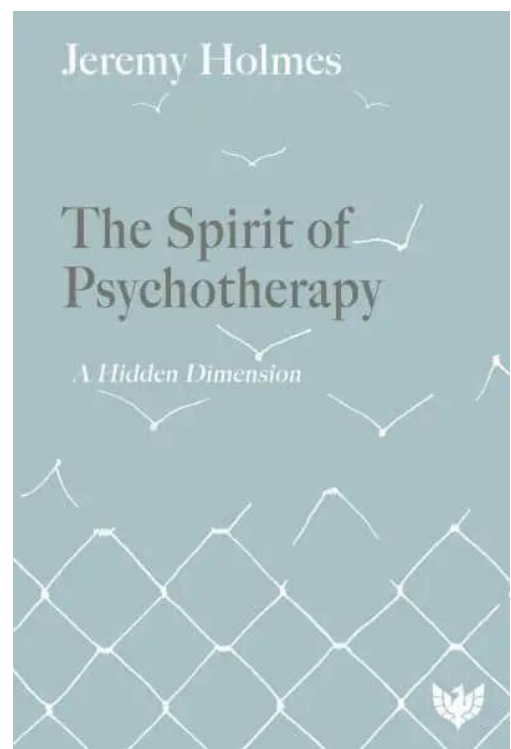
The parallels with therapy were clear. But how could two such disparate cultural formations converge in this way? I still had no answer to the question 'what is going on here?'. My conclusion was that psychotherapy and spirituality's common ground is that they are both strategies for dealing with *radical uncertainty*. In order to survive,

thrive and reproduce we need to be able to predict the future - but the future is by its very essence unknowable. Therapy and religion represent two attempts to resolve this paradox.

At this point I needed a theoretical framework to help me unravel this conundrum. Attachment Theory is my ever-present *vade mecum* and reminded me that to face the future we need a secure base: a parent, child, partner, pet, therapist. With their help we learn to mentalise and so to question our assumptions about the world and modify them where needed. For believers, God is the ultimate secure base: ever present, always able to hear and respond to one's distress.

Beyond Bowlby, I drew on two more minor deities. The first was the neuroscientist and psychiatrist Karl Friston whose work I had explored and applied to psychotherapy in a previous book (Holmes 2020). In his Bayesian Free Energy Minimisation model the mind/brain, in search of coherence and meaning, is always trying to reduce *free energy* by approximating its top-down models of the world to the unbound energy associated with incoming bottom-up perceptions.

In psychological illness this process of attending to sensation and revising models in the light of experience is compromised. From below, feelings are repressed. From above, simplistic and often self-defeating top-down concepts reign, e.g. 'I am inherently unlovable'; 'only if I am thin will I be acceptable'; 'I am a complete failure'; 'the world is too dangerous to venture into'. In PTSD there are no models of the world to encompass the pain of abuse or neglect. Religion offers all-embracing comforting precepts such as 'God is love', or in the case of non-theistic Buddhism, the view that transience and change, and therefore suffering, are universal. Psychotherapy, by contrast, encourages free associative openness to bottom-up sensation and fosters mentalising, in which one's assumptions about the world expressed in transference are developmentally understood.



Friston argues that by creating a 'duet for one', two heads are better than one when it comes to binding free energy. In therapy this is the therapeutic relationship itself. Thus, my third helper was Winnicott and the notion of *transitionality*. This is that play-space between the inner world of feelings and thoughts and the outer world of brute reality. By co-creating a *transitional zone*, therapist and client can learn to play together, to try out ideas, to allow the terrors and horrors of trauma to be felt without succumbing to them. And, by mentalising, to contextualise all our efforts to do so. When there are good outcomes to therapy, the client is now able generate more complex and adaptive models of the self and their world.

Illustrated by clinical vignettes, and backed up with examples from Charlotte Bronte and Tolstoy, my new book tries to bring all this to life. It ends with a personal picture of how I prepare myself for a therapy session and how the background values which inform my work play out in praxis.

### References:

Holmes, J. (2020) *The Brain has a Mind of its own*. London: Confer.

Holmes J. (2024) *The Spirit of Psychotherapy: a hidden dimension*. London: Karnac.

**Jeremy Holmes MD FRCPsych**, a former Chair of the Medical Psychotherapy Faculty, is Honorary Professor at the University of Exeter and established the Exeter Psychoanalytic Studies programme in 1998. Author of over 250 papers and book chapters, his 22 books include *Attachment in Therapeutic Practice* (with Arietta Slade 2017), and the Oxford Textbook of Psychotherapy (with Glenn Gabbard and Judith Beck 2005). Gardening, Green politics and grandparenting now parallel his lifelong fascination with psychoanalytic psychotherapy and attachment theory.

## Aesthetic Attitude in Improvisation and Clinical Practice

**Dr Andrew West**

Retired Child and Adolescent Psychiatrist, Coach and mentor with SE Leadership Academy and Professional Support and Wellbeing Service

I want to share ideas that emerged in the writing of a chapter recently published in an Oxford Handbook<sup>1</sup>. The chapter<sup>2</sup> emerged in the confluence of my involvement with the Collaborating Centre for Values-Based Practice<sup>3</sup> and Oxford Improvisers<sup>4</sup>. I hope to arouse your interest with this brief precis of the chapter.

There are three ideas essential to the argument: Improvisation, Aesthetic Attitude, and Moment.

### Improvisation

The word's roots are in *not-previously-visualised*. Action can have been previously taken, but we have not planned the action that we take next. It seems to be rather generally frowned upon, which is absurd because it is both desirable and inevitable. Each person and situation we encounter from moment to moment, day to day, is unique and therefore demands a unique response, albeit often at the infinitesimally small scale. I stress that, in professional work, improvisation operates within the bounds of accepted clinical practice.

### Aesthetic Attitude

This is probably the most crucial, useful, and teachable concept I discuss. An attitude (to an object, idea, experience etc) can be said to be Aesthetic Attitude if it is stripped of habitual, socially normative, and utilitarian value, and the thing is noticed open-mindedly for its intrinsic qualities. A similar attitude is adopted towards thoughts and experience in Mindfulness Meditation. Free musical improvisers, it transpires, adopt an Aesthetic Attitude to sound without being aware that they are doing so. It is the water in which they swim. They do not judge sounds by traditional musical norms such as

harmony, rhythmic structure, melody, resolution, etc. A grating sound is not immediately presumed to be bad or in error because, heard through the ear of Aesthetic Attitude, it has intriguing attributes. The improvising musician's response has the single most important quality of being sincere.

### **The Moment**

There are moments in clinical practice which feel special, I think because of two characteristics related in a mutually causal way: 1) a qualitatively different connection between clinician and patient, and 2) an aspect of pivot. These moments may coincide with Daniel Stern's Present Moments<sup>5</sup>, which are also special, but in a different way. A given moment might be an example of both, simultaneously, but need not be.

Aesthetic Attitude appears to enable these moments of connection and pivot, which I am calling Aesthetic Moments. The term might mislead, but it redeems itself when revealed as a pun. Firstly, one must grasp the fact that this is nothing about beauty. A moment is Aesthetic if it is one in which an Aesthetic Attitude plays a significant part in greeting and responding to events as they unfold. The moment may be subjectively beautiful to someone, but that is not the point. What is more, whilst it may evidence good clinical practice, it is not particularly likely to be *generally recognised* as such. It will be difficult to code, record, and remunerate. One of my hobbyhorses, elaborated elsewhere<sup>6</sup> is that the way that we treat patients *between the lines* of recognised clinical treatments may nevertheless be important aspects of good clinical practice. (Not giving ten people the same 9am slot in outpatients might be an example.)

The pun, which I am particularly pleased about is that, in physics, "moment" refers to "the rotational effect of a force". This reveals a rich source of images pertinent to clinical change: the lever empowering movement; the slingshot effect exploited in space travel to achieve acceleration and change of direction; any connection that can translate linear into angular momentum.

The most powerful moments in therapy may not be the ones most dominated by the clinical method, though they will always be safest to the clinician and the patient if conducted within a recognised and respected clinical method, just as free musical improvisation respects fundamental social norms and the integrity of the instruments. They may be moments when rigid norms have slackened, perhaps due to accident, humour, or misunderstanding. The patient and clinician find themselves valuing the moment for unconventional reasons, and their next actions are not dictated by (though should remain consistent with) protocol. The clinician improvises and does so with the utmost sincerity and with their ethical selves fully engaged, as it is precisely in situations that protocol does not cover, that ethics are required. The moment passes and leaves a trace for the participants which may be recognised immediately, or linger, to surface later.

If there is substance to this argument, then it is worth further exploration and understanding by clinicians and their trainers.

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- 2) West, A. An Exploration of the Aesthetic Moment in the Clinical Encounter Using Free Musical Improvisation as a Model in op. cit. (1) <https://academic.oup.com/edited-volume/46864/chapter-abstract/421441690> doi: <https://doi.org/10.1093/oxfordhb/9780192866929.013.56>
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Andrew West October 2024

<https://www.developmentalconversations.co.uk/>

## Power, Conflict and Leadership (Royal College of Psychiatrists talk - April 2024)

**Dr Roger Kennedy**

Psychoanalyst in private practice, former Consultant psychiatrist at the Cassel Hospital, former President of the British Psychoanalytic Society

### Introduction:

The subject of the meeting, Power, Conflict and Leadership, covers themes which could easily fill a term's lectures, so I am necessarily going to be personal and selective in what I present. I will focus on the NHS, where one could say these days, professional staff often feel powerless, immersed frequently in situations of toxic conflict, and surrounded by fragmented and at times coercive leadership from above, with an emphasis on accounting rather than accountability and where trust in professional expertise has broken down. This is accompanied by poor morale, lack of belief in the system along with job dissatisfaction, a contrast with the early years of the NHS where job satisfaction and a sense of belonging were common. As Onora O'Neill described in her 2002 Reith lectures,<sup>1</sup>

'Doctors speak of the inroads that required record-keeping makes into the time they can spend finding out what is wrong with their patients and listening to their patients...The new accountability is widely experienced not just as *changing* but...as *distorting the proper aims of professional practice* and indeed as damaging professional pride and integrity.'

<sup>1</sup> O'Neill, O. (2002, p. 50 ff).



She charts how measurement and control has led to a culture of suspicion with perverse incentives such as targets and performance indicators, leading to low morale, professional cynicism, and public mistrust. Instead, she calls for an 'intelligent accountability' which does away with excessive regulation, and where professionals are trusted to be professional. Incidentally she also cautioned against undue reliance on information technologies, as, though they may be anti-authoritarian, they are also often used in ways that are anti-democratic. 'They undermine our capacities to judge others' claims and to place our trust.'<sup>2</sup> Her diagnosis and warnings remain relevant today.

I would add that the emphasis on evidence-based practice, though important in the right context, can become unhelpful when pushed too far. Donald Schön distinguishes between a 'high, hard ground where practitioners can make effective use of research-based theory and technique, and... the swampy lowland where situations are confusing "messes" incapable of technical solution.'<sup>3</sup> He points out that the difficulty with the problems of the high ground, however great their technical interest, is that they are often unimportant to clients or the larger society, whereas the problems of greatest concern are often located in the swampy lowlands, where one uses experience, trial and error, intuition and muddling through. Good professional practice often needs this latter approach if real life problems are to be tackled; it's more an art than a science and requires what he calls 'reflection-in action,' where one is constantly adjusting to the situation, and working with others to try to find out what works. Reflective practitioners use wisdom drawn from on-the-ground seasoned experience augmented by technical expertise to undertake effective action in the swampy zones of practice.

To provide some context for looking at current NHS difficulties, I will briefly go over some NHS history from my experience in the 1950's to now, as well as my experience of running teams in order to look at poor as opposed to helpful leadership. I will also examine some of the anxieties involved in working within a big organization like the NHS. At the end I'll have a go at speculation about how to completely change the way the NHS is currently organized, not just yet another managerial reorganization but a radical change which involves e.g. no external targets, no top-down management, where meetings are only for self-reflection, conflict can be generative, and groups of staff self-manage in self-reflective spaces. This would involve a redistribution of power, and trust in professional expertise.

Such radical distributions of power are occasionally possible, as described for example by the Czech writer and then politician Vaclav Havel. In his essay *The Power of the Powerless*<sup>4</sup> he pointed out how in the modern totalitarian state the centre of power is identical with the centre of truth; only the centralized state has the truth, which the individual cannot question. The way power is structured then affects everyone; by insisting that truth is in the centre, the individual lives a lie. He points out that this is possible in part because humans are capable of being easily seduced by the offer of clear answers and certainty.

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<sup>2</sup> O'Neill, O. (2002, p.91).

<sup>3</sup> Schön, D. (1983, p.42).

<sup>4</sup> Havel, V. (1986, p. 46).

Havel describes how this occurs with the manager of a fruit and vegetable shop, when he places a communist slogan in his window to ingratiate himself with the authorities, whether or not he agrees with the slogan's content. Havel describes how multiple similar acts bolster up and bind together the entire totalitarian power structure, with the 'glue' of a lying ideology focused on the notion of some central site, often personified in the single dictator and/or their party machine, where 'truth' can be found. However, Havel also and prophetically, imagined what could happen one day if the greengrocer were to snap and stop putting up those slogans. If that act were repeated all over, then he suggested that the entire pyramid of totalitarian power, deprived of the element that binds it together, would collapse in on itself, in a kind of material implosion. This would be a revolution of the powerless, as occurred in central and east Europe in 1989. At that moment, there was a mass refusal to tolerate the intolerable.

One cannot of course underestimate the *trauma* of being on the receiving end of persistent intolerant regimes, governments, and rigid organizations, particularly where obedience to a destructively narcissistic leader or powerful group dominates. The Czech psychoanalyst Michael Sebek, having experienced at first hand living through the traumas of a communist regime, has written about the psychological processes involved in totalitarian regimes, emphasizing what he calls the '*totalitarian object*' that can come to dominate individuals in a repressive society, but may also function in post-totalitarian regimes as well as at times in more democratic societies. This is a repressive and intrusive form of psychic structure that becomes internalized in a society that demands compliance and obedience, where there is *low tolerance* for the difference of others, stressing unity and sameness. In addition, '*Totalitarian objects (external and internal) may also bring some safety to immature persons who like to merge with a strong authority in order to get a feeling of importance and wholeness. The idealization of totalitarian objects may be an important device for saving objects from destruction and using the process of splitting to attain some psychic balance.*'<sup>5</sup>

There is always a risk that the totalitarian object may take over the individual and the group's functioning creating a rigid intolerance towards anything outside the narrow functioning prescribed as acceptable. This is visible not only in a totalitarian society but also in pockets of other forms of society, such as with radicalized youth, terrorist groups or any extreme political organization that demands compliance, obedience coupled with an identification with charismatic leadership; and too in pockets of the health service, where whistleblowing is penalized and bullying rife. When the identity of the individual or the group is in jeopardy, the tendency is to close ranks against that which is perceived as a threat. It is at this point that the individual and the group become most vulnerable to the charismatic leader who promises an illusion of power and security, or the groupthink of a dysfunctional centralized organization. Omnipotence reigns.

Remedying the dysfunctional NHS system seems a Herculean task. It's what's known as a 'wicked' problem as opposed to a 'tame' problem.<sup>6</sup> A tame problem may be complicated

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<sup>5</sup> Sebek, M, (1996, p. 290).

<sup>6</sup> Rittell, H. and Webber, W. (1973), pp. 155-169.

but is reasonably easy to resolve. For example, the NHS is good at dealing with life and death emergencies; there are no committees to decide whether to operate on someone with a severe injury following an RTA. A wicked problem is both complex and complicated with no easy solutions ready at hand, e.g. changing the NHS culture to one that satisfies both patients and staff. Such problems often require so-called 'clumsy' solutions,<sup>7</sup> using a variety of interventions, but in protected spaces where dialogue can take place. And the diagnosis of the problems the NHS faces today is complex, and it's not just about money but rather about how to understand and remedy dysfunctional relationships. Hence perhaps a psychoanalyst can make a stab at understanding what is happening today; after all psychoanalysis is at heart a theory of and about internal and external conflict.

I can only point out some of what I have seen and experienced in over 40 years working in the NHS, nearly 30 as a Consultant at the Cassel Hospital; 10 years chairing the local BMA negotiating committee; working in the last 14 years mainly in a multidisciplinary private clinic, The Child and Family Practice in London; from my time helping to run a substantial charity, The Institute of Psychoanalysis; and my daily work as a psychoanalyst, where some of my patients have been and are still suffering the agonies of trying to keep alive clinical work with their patients in an NHS environment that often fails to support them, or erodes their trust in their clinical capacities. Of course, there are always islands of sanity, and excellent teams who can manage their hostile environment and keep their enthusiasm going. There are GP practices where you can easily speak to a receptionist and obtain an appointment - my own GP's practice in Twickenham for example. But there are also significant failures. In my own field, half of my clinic's work is doing what CAMHS should be doing and used to do - seeing depressed adolescents in a timely fashion, undertaking neurodevelopmental assessments in weeks not after years of waiting, and helping parents manage their children's day to day emotional and behavioural challenges, as well as offering ongoing and sometimes intensive psychotherapy.

### **Institutional Anxieties**

When I was first asked to speak on this topic, I immediately had 2 strong images come to mind, one from Dickens's novel *Little Dorrit* and one from my time at the Cassel - the former involving the 'Circumlocution Office' and the latter involving replacing chandeliers in staff offices. If you bear with me, I think you will see the relevance of these images to the themes of the talk.

In *Little Dorrit*, a novel where Dickens criticizes much of Victorian society, he describes various states of imprisonment, centred around the Marshalsea, the debtor's prison where Dickens' father was held when Dickens was about 12; an experience which remained deeply traumatic for the writer, as he was sent to work in a blacking factory at that time. You may recall that in *Little Dorrit*, there is a chapter on the 'Whole science of government'.<sup>8</sup> The Circumlocution Office, administered by the Barnacle family, was the most important Department under government; no public business of any kind could

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<sup>7</sup> Grint, K. (2010, p.23-5).

<sup>8</sup> Dickens, C. (1857, p. 119 ff.)

be undertaken without its acquiescence, its finger was in the 'largest public pie, and the smallest public tart.' It was equally impossible to do the plainest right and undo the plainest wrong without the express authority of this office. In this Kafkaesque nightmare world, 'If another Gunpowder Plot had been discovered half an hour before the lighting of the match, nobody would have been justified in saving the parliament until there had been half a score of boards, half a bushel of minutes, several sacks of official memoranda, and a family-vault-full of ungrammatical correspondence, on the part of the Circumlocution Office... Whatever was required to be done, the Circumlocution Office was beforehand with all the public departments in the art of perceiving – HOW NOT TO DO IT.'<sup>9</sup> No one who went to this office could ever get their business dealt with, it was always put off, sent to committees or was lost in endless cycles of minutes and paperwork.

This is of course a mad world, and a paranoid one, unfortunately only too familiar in the modern world where we know how much the power of bureaucracy can crush individual creativity and autonomy. It is also characteristic of certain defensive positions that organizations can adopt, particularly when change is threatened. It shows in a dramatic way what can go wrong in public institutions when they lose touch with human agency. This has been well described by the classic work of the psychoanalyst Isabel Menzies Lyth in her papers on the functioning of social systems as a defence against anxiety.<sup>10</sup> As a result of studying the Nursing Service of a major teaching hospital in the late 1950's, she described the high levels of tension, distress and anxiety amongst nurses, and how this reflected not so much the nature of their day to day work but how the organization failed to manage primitive and at times psychotic anxieties. For example, student nurses were constantly moved around rather than spending time getting to know other staff and feeling secure in what they were learning; nurses were often on the receiving end of anxieties about crisis and operational breakdown; nurses on the coal face felt they were given little responsibility or trust, so that they ended up not taking responsibility and delegating upwards. Then no change was possible, and rather like in the world of the Circumlocution Office, nothing was done about this. Of course, one could add that dysfunctional organizations both create and fail to manage psychotic anxiety.

My other image comes from the late 1980's at the Cassel Hospital. The Hospital used then to have about 55 beds for adults, families and adolescents. It was organized around consultant units, but also as a psychoanalytic therapeutic community at the whole hospital level. The task of the Community Team led by the Medical Director was to pay attention to the functioning of the whole community, through various whole hospital meetings. The ethos of the Cassel was to encourage responsibility and to help patients re-establish their links with ordinary social life which had often broken down. Thus, attention to everyday tasks such as cooking and cleaning with nurses alongside patients was part and parcel of the therapeutic work, the 'Work of the Day.'<sup>11</sup> The fabric of the hospital was looked after by health service staff for the consulting rooms, but by

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<sup>9</sup> Dickens, C. (1857, p. 119).

<sup>10</sup> Menzies, I.M. (1988).

<sup>11</sup> Kennedy, R. (2007, p. 246-260).

patients and nurses working together in patient areas. Multiple transferences were worked with, at the individual level with individual and family therapists, but the wider transference to the setting or the hospital environment (including the fittings and fixtures) and community was also examined and informed individual work. The relationship between nurses and therapists was looked at through the supervision of the nurse-therapist relationship, in particular countertransference feelings both in relation to patients and to the fellow worker. It was a powerful therapeutic tool, much used by visitors from Europe and the US.

Until the late 1980's the hospital maintained a certain autonomy in making decisions about its structure and running. That all changed with the introduction of an increasingly bureaucratic management organization at the Health Unit of which we were part.

One day the facilities directorate people came and looked at the lighting and insisted that all the very pleasant chandeliers in consulting rooms had to be removed as they were not modern enough. We protested but in the end to no avail, and all the light fittings were removed, although somehow they agreed to leave one original chandelier in the Medical Director's office, as if to remind us of what we had lost. The chandeliers were replaced by hideous strip lighting which required knocking into the fabric of the ceilings (some of which were early Georgian, others Victorian). Instead of the warm human light of the chandeliers we had the new harsh impersonal light, emblematic of how things were changing in the NHS, not just at the Cassel.

Incidentally, to illustrate how mental health can be deeply affected by living spaces, years ago when I was training as a psychoanalyst, I earned extra money to help fund my training by doing GP work at the old Holloway Prison for a couple of years. This meant seeing all women prisoners who came in and out of the prison from court, to check on their physical and mental health. The doctors' area was outside the main prison but was like the rest of the place part of a large old Victorian building with high ceilings and several large windows. Disturbance was fairly minimal despite the women's significant mental health issues, and the GP intake service was well managed by a very experienced and caring nurse. However, this all changed when a new prison was built next door, and the inmates were transferred. Within days, in this new red concrete structure with very narrow windows, major outbreaks of disturbance began to be a regular feature; soon all the windows were broken, and screams were often heard from women shouting through the bars. I soon left. Whatever the limits of the old Victorian structure (which was demolished) it provided a safer space for very traumatized people. The new prison was also subsequently demolished, as not fit for purpose.

This reminds us again that transference to places and physical settings needs to be taken account of when looking at structure and function of the workplace, and that includes during individual psychoanalysis, where sometimes the transference to the setting, which can involve primitive anxieties and emotions, predominates.



I think that the way physical structure and psychic structure interact is related to the presence in us of a psychic structure which I call a '*Psychic Home*,'<sup>12</sup> the sense of having a secure internal home base, as a key feature of identity. Such a home base is built up from several different elements, as with the physical home, which forms its substrate. Indeed, the physical reality of the home and its psychical representation are intertwined. The psychic home is made up of identifications, as well as cultural and social influences.

Workplaces can become like homes. The NHS has been a home equivalent or even a literal home for many professionals, a place they can strongly identify with as an egalitarian and idealistic institution people care about, as was possible at least for the first 30 years or so of its existence. When our physical home is threatened or literally attacked, it has an impact on one's psychic home and thereby one's sense of being, even one's whole sense of professional identity. Those of you whose homes have been burgled, or whose services feel under constant threat may recognize the intensity of these kinds of feelings.

### **Conflict and Leadership**

Conflict in organizations is inevitable - it's part of human nature, but it makes a difference how it is handled, and the atmosphere within the organization can perpetuate or reduce conflict. There are controlling climates and trusting climates. Much depends upon the responsiveness of the organization's leadership, whether or not they *listen*. I mean *really* listen not pretend to do so. There is nothing more frustrating than going to a meeting of a large corporation who are 'Here to listen,' which can be translated into, 'You are here to listen to *us*.'

There are many books dealing with these issues, too many to cite here, though one of the earliest and most fruitful is *Understanding Organizations* by Charles Handy.<sup>13</sup> One of the main points he makes is that power and influence over others is a major source of conflict.<sup>14</sup> Symptoms of unhelpful conflict include poor communication vertically and horizontally, intergroup hostility and jealousy, interpersonal friction, proliferation of rules and regulations, meetings about meetings, and low morale. These symptoms are more likely to occur when people lose sight of the goals of an organization, when roles become diffuse or confused, and when there is too much fighting about territory.

There are no easy answers to treating these symptoms, but it helps if there are agreed shared goals, a climate of curiosity, and trust in professional expertise as well as respect for people's autonomy.

There are many styles of leadership, depending upon personalities and kinds of organization and the level within an organization. Again a vast amount has been written on this subject, but from my own experience of leading teams, I would suggest that poor leadership consists of a leader or leadership group being unable to take effective decisions, avoidance of tackling conflicts, a leader with a predominant wish to be loved

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<sup>12</sup> Kennedy, R. (2014).

<sup>13</sup> Handy, C. (1976).

<sup>14</sup> Handy, C. (1976, p.299 ff.)

rather than take awkward decisions, a leader with obvious favourites, who cannot delegate, cannot manage their anxiety and transmits it to the team, or who is blind to their own shortcomings. Basically, the poor leader is insecure in their own authority, which leaves the rest of the team having to pick up the mess the leader leaves behind (if it is lucky enough to have one or more individuals capable of taking responsibility), or it remains dysfunctional, or worse, goes under. In the private sector that may mean going out of business, in the state sector being closed or limping on and on with a poor performance.

There is a difference between power and authority, and several ways of defining both concepts. Power is more about the capacity to influence others, and authority about having the legitimate right to exercise that influence. For example, if a team leader is well qualified, experienced and makes sensible decisions, or has good insights into a clinical issue that the team finds helpful, then the leader will have natural clinical authority. They are then tacitly given the right to influence others. If in contrast they are incompetent, weak, or constantly anxious, they have the power to influence others by virtue of their position, but little personal authority; people will not take them seriously, will not follow their lead, or will just do their own thing to the detriment of the organization. Power without authority is vacuous. Authority without power is frustrating. A certain amount of both reasonable power and authority is needed for a team or an organization to fulfil its function effectively.

Effective team leadership involves not only avoidance of poor leadership behaviour, but also an ability to tolerate people's anxiety and help them process it, keeping to the agreed task but being flexible enough to adapt to changing circumstances, backing the team (but not colluding with boundary breaking), making it clear the buck stops with the leader, being able to delegate where appropriate and foster team members' development, and listening closely to team members and giving them space to give their view. It helps to understand large group dynamics and the power of projection, for example, that it is easy to feel mad in a large group, difficult to feel sane. I think it also helps for the team in clinical meetings to come up with an agreed *focus of work*, which can then be tested and modified if necessary. In short, effective team leadership consists of having a clear aim in view, listening to many voices but then formulating a focus of work which can be tested by 'self-reflective practice', to quote Daniel Schön.

These suggestions apply to fairly traditional organizations. However, there are other ways of viewing how organizations can run effectively, which I shall come to after some NHS history.

### **NHS History**

So, what has happened to the NHS? I think it may help to look briefly at its history to see what has changed, what changes were necessary and what were mistaken and need to be corrected. Being only a year younger than the NHS, I feel I have a reasonable experiential overview of what has happened since it was founded on the 5<sup>th</sup> of July 1948.

The original organization and leadership of the NHS was easy to understand, comprising a three-tier structure, with the *Minister of Health* at the top responsible for the service,

taking control at its inception of 480,000 hospital beds, 125,000 nurses and some 5,000 consultants. The three tiers consisted of *Regional Hospital Boards* responsible for hospitals, specialists, ambulances, psychiatric care, blood transfusion, research, and a few other services; *Local Health Authorities* responsible for community services such as midwifery, maternity services and child welfare, health visitors, vaccinations, domestic services, etc; and *Executive Councils* responsible for GPs, dentists, pharmacists, and eye services. The tiers were designed to interact with one another to suit the patients' needs. There was a private sector which ran in parallel, sometimes using beds within NHS hospitals, so-called 'pay beds', or even a whole separate private area. Some GP's remained solely in private practice. But the private sector remained a relatively small sector at that time. The BMA initially voted against the NHS being formed, but to keep them on board Aneurin Bevan agreed that consultants could keep a private practice. The fantasy of the consultant with a private practice and a Bentley was a caricature which remained even when in 2003 the new consultant contracts came in. Politicians and civil servants I think were deeply shocked about how much work most doctors undertook, often working way beyond their contracted hours.

Hospitals were run with a medical director or superintendent, a lead nurse or Matron and a hospital administrator whose job was to administer, not manage. There might also be a hospital board consisting of interested locals supporting the running of the hospital.

The NHS soon ran into financial difficulty because of the massive demands on what quickly became a popular service, free for everyone. To address this dilemma, some charges or contributions for prescriptions, glasses and hearing aids were soon brought in.

What was it like to be a patient then? Was it like what you see on *Call the Midwife* on TV? The programme certainly stirs up a deep and at times tearful sense of nostalgia in many people, including myself. I recall that we had a quite personal relationship with the local GPs, who were greatly respected. One GP sat all night with my 6-year-old brother when he had a severe bout of bronchitis to make sure he didn't choke to death. The era of delegated on-call services had not yet arrived. In the 1950's polio was a scourge, and not confined to the poor and deprived; there was enormous fear that we would end up confined to an iron lung for months on end in order to breathe. So, it was a great relief when the polio vaccines came in in the mid to late 1950's. Then as recently with COVID, the NHS was able to vaccinate the population with remarkable efficiency.

After hospital admission you could spend some time in a convalescent home before returning to your own home. I recall doing so after my tonsillectomy at the newly opened Chase Farm Hospital Children's Ward when I was 10. These homes, tragically closed in the 1980's, had an important role in enabling a smooth recovery, a bridge between hospital and home.

However, 2 years before that operation I spent a few nights in an adult male surgical ward with possible appendicitis – it turned out be mesenteric adenitis. The 14-year-old next to me and I were the only children. On the one hand the men were quite good to

us and tried to make us feel at home by joking with us. But at night there were often cries of pain from those who had just been operated on, which was frightening. Actually, it was at that admission that I first began seriously reading, spurred on by the 14-year-old who had a massive pile of comics and books to help pass the time.

Seeing a consultant was possible but there never seemed to be an efficient appointment system. So, you had to take reading matter to help pass the 3-4 hours you might have to wait. At least you didn't have to wait weeks or months to see them.

I recall as a boy seeing scarlet fever wards, hearing about shacks where TB patients were still confined (Streptomycin had only just been put into use), and general fever wards tucked away from the main site. Women might have their babies in hospital or a separate maternity home, but there were a fair number of home births, as seen in *Call the Midwife*. Also, when I was a medical student, we learned to undertake breech deliveries rather than as now automatically perform caesareans, no doubt now with fewer disasters.

As for the staff, cleaners in those days were integrated into the ward structure, very much part of the team. Wards were clean, if smelling of carbolic or whatever it was that was responsible for that hospital smell. Sisters oversaw the ward, and the Matron was 'she who would be obeyed.' Nurses really ran the hospitals. Later, as a young doctor you soon learned, if you had any sense, to get along with the Sister if, for example, you wanted a relatively quiet night on call. Signatures for medicines could wait until the morning. But if you antagonized the Sister and the nursing staff, you could have a busy night.

There were ongoing pay disputes as now; that has been a constant.

And it was not all wonderful, though staff morale was generally good, with a strong identification with the aims of the NHS to provide for everyone as part of the welfare state. The sense of reasonable entitlement was linked to the strong feeling of community as well as a desire for radical change that came out of the second world war experience of people of all classes working together for the common good. So the recommendations of the 1942 Beveridge Report proposals for the introduction of a welfare state were ready to be put into place with the Labour government.

On the down side, many buildings were antiquated and in need of repair, babies were separated from mothers – the Cassel Hospital was the first place in the 1950's where women with post-natal breakdown could be treated while their babies were with them; and of course it was only gradually and as a result of the studies by psychoanalysts such as John Bowlby, Anna Freud and the Robertsons that parents (mainly mothers) were allowed to remain with their children during hospital stays.

When I was a House Officer after qualification, my cohort in 1974 was among the first to have off duties – on every other night. Until then you were on duty for 6 months at a time non-stop. Even so, as I did the ENT job at UCH, I worked about 133 hours a week, and when I was on duty, I was on for much of the night, dealing with bleeding

noses from fights at Euston Station, fish bones stuck in throats from nearby restaurants, or the occasional object a child had pushed up their nose. It felt like paradise when I then did my medical house job at Northampton General Hospital, a 1 in 5 rota.

Of course, attitudes in staff relations and towards patients reflected attitudes of the period, as always. Thus, when there was an influx of Asian doctors to fill much needed GP vacancies, particularly in deprived areas, racism was not uncommon, with snide comments about their qualifications. Antisemitism in the 1950's and 60's meant it was more difficult for a Jew to find a consultant post at a major teaching hospital. At my time at medical school in the late 60's there was about a 25% female medical student quota. Sexism and paternalism were more common than now, but so was old-fashioned courtesy.

A major and basically positive change in the care of the mentally ill occurred with the decision to close many of the old asylums, a process which only really got under way in the mid 1980's. But this sometimes also entailed a flood of institutionalized patients ending up in seaside boarding houses with poor aftercare.

The plague of NHS perpetual reorganization began under the Heath government when in 1974 a new NHS structure with Regions, Areas and District, each with their own bureaucracy, was introduced and then fully implemented by the Wilson Labour government, even though Labour had been against the changes when they were first proposed. Eventually the area level was abandoned, but by the 1980's with the Thatcher government, a whole new level of reorganization began with the New Public Management ethos of the 1980's and 90's, when, 'the British public sector was ostensibly transformed from lethargic and bureaucratic leviathan to agile service deliverer through the encroachment of the market and the discipline of targets and performance-management systems.'<sup>15</sup>

A whole new language was introduced. Flagging up, rationalization of services, creating pathways, affordability, corporate vision, etc have become embedded in the culture. A phrase I recall being used repeatedly by the District General manager who tried unsuccessfully to close the Cassel Hospital in 1990 was 'we can't provide everything for everybody; there is infinite demand and only finite resources.' That was really code for 'we are going to make cuts.' This also went against the whole ethos at the heart of the founding of the NHS; it echoed the dire warnings of those in 1948 who were opposed to its inception, who predicted incorrectly that it would quickly collapse due to excessive demand.

I think there has been a fundamental mistake in thinking that you could apply a model of private medicine and market forces to the NHS. Private medicine has its place, it's not going to go away. But from my experience in this sector, it has to be focused on particular services, a particular market; it cannot provide a universal service like the NHS. For example, my own clinic only has one administrator for about 50 part-time faculty members. We have a Board, which meets monthly, informed by our accountant's

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<sup>15</sup> Grint, K. (2010, p. 44-5).



monthly figures so we can keep tabs on cash flow etc. In the last year I alone have seen 199 new patients and undertaken 350 follow ups on 2 clinics a week, many times the patients I saw in the NHS. But we can't offer 24-hour emergency care. Families who use the clinic are not always wealthy; many decide to use their limited financial resources to see us as they do not wish to wait for months or even years for their child to be seen by the NHS.

The NHS can learn from the private sector how to be less bureaucratic, drastically reduce useless meetings, have very clear goals, with more autonomy for the practitioner and being closer and more responsive to the patient's needs. When I was in the NHS my secretary was a kind of firewall to protect me from external demands. But now I have a direct and more personal relationship with parents.

But now the NHS no longer has a clear leadership structure going straight up to the Health Secretary, private firms have muscled in on many services, fragmenting the whole organization which used to have clear boundaries, and services which were an integral part of a whole system have been outsourced, creating fragmentation and splitting, a recipe for breakdown. As private medicine is good at targeted services, there is a tendency for them to cream off the more profitable work, leaving the NHS to pick up the pieces, but it can't respond adequately as services are often *in* pieces and impoverished because of systemic failures, depriving NHS staff of job satisfaction, leading to yet more fragmentation, even in small specialist units where some sense of autonomy is possible. The sense of breakdown and failure only increases the intensity of the psychotic anxieties described by Isabel Menzies-Lyth.

### **A Transformed NHS – Speculations**

As I indicated at the beginning, I will end by making some speculations about how to transform the NHS back into a happier and more fulfilling organization – not perfectly happy, but happy enough.

For this task I have been influenced by the work of the Belgian business consultant Frederic Laloux, as described in his book *Reinventing Organizations*.<sup>16</sup>

Based on consultations with a number of highly successful organizations, including those involving health care professionals, he put forward the view that we are going into a new era of organizations where the old hierarchies and assumptions no longer apply. These organizations have discarded age old leadership principles in favour of completely new ways of working together. For example, the Dutch neighbourhood nursing organization Buurtzorg uses teams of nurses of 10-12, with each team serving about 50 patients in a small neighbourhood. The team is in charge of all the tasks previously fragmented in inefficient ways across different departments. Nurses take time to be with the patients, the same patient sees the same nurse, and there is an emphasis on the patient's autonomy. These teams have no boss, no targets and no performance indicators yet they easily outperform their competitors. The teams are self-governing and self-organizing; there is no middle management, which saves a considerable

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<sup>16</sup> Laloux, F. (2014).

amount of money. There are external coaches who help teams self-reflect but have no controlling role. Decisions in Buurtzorg are made by an 'advice process,' where different teams meet in person or online to share latest ideas and developments. Laloux describes how in a traditional pyramid organization, meetings are needed at every level 'to gather, package, filter, and transmit information as it flows up and down the chain of command. In self-managing structures, the need for these meetings falls away almost entirely.'<sup>17</sup>

This is just one of several companies who have become incredibly successful, both in financial terms but also with regard to patient and community satisfaction, often becoming the dominant service. Buurtzorg now has about 7,000 nursing staff throughout the country.

Can one apply this kind of thinking to the NHS? There would certainly have to be some sort of transition process. In some ways it would mean returning to the original model of the NHS however modified, with a focus on local communities and smaller units, not vast, unwieldy, and impersonal organizations as now. Probably small specialist units as well as GP practices would begin the process of self-managing without external controls and targets. I would suggest the first stage would be to set up forums all over the country, safe self-reflective spaces where staff could come together to brainstorm how to set up their own self-managing unit. This would involve a redistribution of power, and trust in professional expertise. Is this too utopian a view? I certainly think the NHS needs reinventing.

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<sup>17</sup> Laloux, F. (2014, p. 76).

## What does it mean to be a CAT-informed Psychiatrist?

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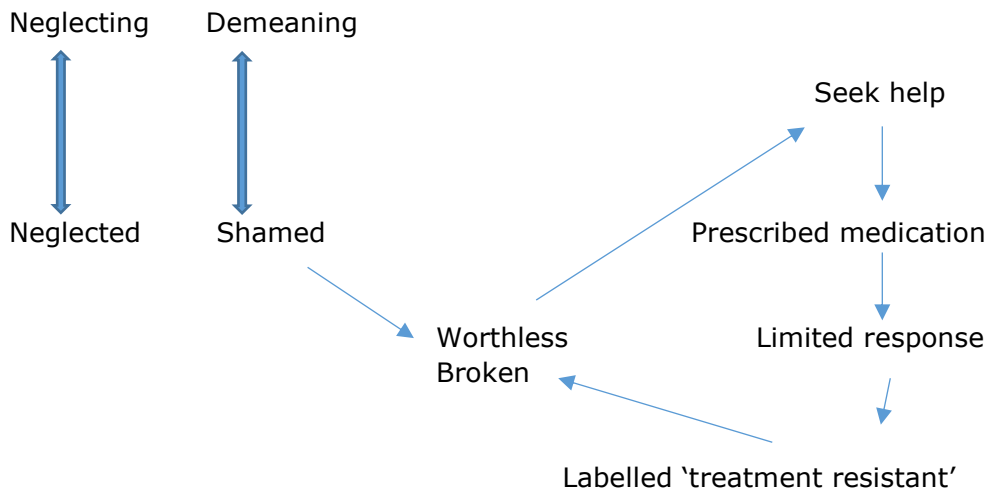
My current timetable stipulates that I work as a therapist on a Thursday morning, seeing two clients for Cognitive Analytic Therapy (CAT) as well as having supervision, and as a Liaison Psychiatrist in the afternoon, dealing with a wide array of crises related to mental and physical health. This presents what may seem on the surface a trivial conundrum; do I wear scrubs to see my CAT clients, or do I wear my therapist outfit (nice corduroy shirts, black boots), to walk around a big chaotic hospital full of sick people? This dilemma is symbolic of the challenge that I face in straddling two modes of working, which deviate significantly in culture, ethos and methods. I have seen clients who invite me to diagnose them in therapy sessions, which I resist. Perhaps they would rather see me in scrubs. Equally I have seen patients on the 9<sup>th</sup> floor of a hospital in a bustling ward, who could really benefit from therapy.

Clothing isn't the only dilemma. There is also a language problem. I see clients and patients in the same day and must make sure not to confuse the two terms. For the purposes of this essay, I will refer to people in the care of mental health services as patients (unless directly referring to clients whom I have seen for CAT) since this is how they are known in psychiatry, as I reflect from my position as a psychiatrist. The difference in terms is significant, with the term 'client' empowering, and the term 'patient' potentially disempowering and suggestive of a 'sick person'. The use of medical jargon can perhaps create a sense of difference and alienation, a doubting of a patient's own feelings and interpretations, and for some, this sense of feeling unvalued or not listened to can feel all too familiar as I will touch on later in the article.

### Negative Capability

First coined by John Keats in an 1817 letter, Negative Capability was described as the ability to accept "uncertainties, mysteries, doubts, without any irritable reaching after fact and reason" (Gunderman, 2021). Displaying negative capability is thus the opposite of a didactic approach, and one that is recognisable in the non-expert position and collaborative approach of a CAT therapist. In lacking this 'negative capability', psychiatric treatments can have inherently idealistic treatment goals.

Inherent in biological models of mental illness, is the notion that correction of biological imbalances in brain chemistry can 'cure' a person of suffering. Not only does this notion lack any basis in evidence, (Moncrieff, 2014), it also obscures social and political realities which are influential to a person's suffering and that no medication could hope to cure. This could manifest itself in a problem procedure as shown below in the partial Sequential Diagrammatic Reformulation (SDR) (Figure 1), where the treatment only serves to intensify feelings of being worthless or broken: "I must be really messed up, not even antidepressants are working."

**Figure 1**

When these idealistic expectations of treatment are not lived up to, the intensifying feelings of worthlessness and helplessness could lead to a sense of passivity and dependence on medication and services.

"Confronted with the limitations of a mental health service, or any service provision, the need to be 'fixed' or cured, can become easily frustrated, because the need may be unmet, as well as unrealistic" (Bell, 2017).

These expectations might also allow a doctor to protect him or herself from the political reality, perhaps uncomfortable to acknowledge, that there are factors beyond our control. Perhaps the associated sense of hopelessness can be overwhelming or undermining to a doctor's identity, as somebody trained to 'make people better,' as they fail to live up to an omnipotent ideal. Furthermore, not acknowledging this reality could draw doctors towards increasingly drastic medical solutions which become increasingly punishing or coercive for patients, as I will look at in a case example later in the essay.

In my experience patients tend to have an intuitive sense of what underpins much of their suffering. However, this nuanced and 'expert' understanding of their own problems is too often dismissed and reframed in rigid medical language. For example, a patient might talk at length about the nature of their current suffering, and this might be met with a question like 'so how long have you felt depressed?' or 'have you lost interest in activities that you usually enjoy?' As Thomas Kuhn observed: "The medical model could only reflect psychiatrists' perception of 'truth'. Psychiatrists' understanding of mental disorder had no intrinsic claim to greater legitimacy than their patients' or anybody else's." (Poole and Robinson, 2021).

The collaborative approach of CAT seeks to find a common language without its own "perception of truth, in building an authentic therapeutic relationship, that facilitates access to the deeper knots of one's mind, which might be voiceless, or held back

through shame. A medical approach is likely to fail to access these knots, leaving a superficial or 'paper self'" (Aves, W. 2024), that they may not recognise.

### **Resisting the urge to rescue or punish**

Working in acute care, time to discuss and reflect can be especially limited. In my role working in liaison psychiatry, I became aware of K, a 28-year-old lady who has a diagnosis of Emotionally Unstable Personality Disorder, and who is well known to mental health services, being referred frequently by medical wards after treatment with N-Acetyl-Cysteine (the antidote to paracetamol toxicity). On this occasion K had repeatedly absconded from the ward to take further overdoses of paracetamol, increasing her risk of liver toxicity, which could require treatment via a liver transplant, or result in her death. I wondered if K's behaviour was powerfully drawing the treating medical team into the top pole of reciprocal roles, which they may not have the training or reflective capacity, in the emotional charge of that moment, to recognise. The draw was towards increasingly oppressive care, whether by rescuing (in an ideally caring top role) or punishing (in an abusing top role). The result was that K was restrained, sedated and intubated, so that she could receive treatment. Unfortunately, K then suffered complications when the intensive care team were taking her breathing tube out, and for a period her brain was starved of oxygen.

Without the training or experience to understand behaviour in patients with EUPD, and without an awareness of the powerful emotional pulls their behaviour can exert, it must be overwhelming and bewildering for medical staff to manage these crises. A psychotherapeutically trained or informed psychiatrist can sit with the patient's (and staff members') unmanageable distress, attempting to contain it, resisting the urge to be pulled into punishing or rescuing roles, understanding that some reflective capacity could potentially be reinstated if this emotional distress were soothed, for both patient and healthcare staff alike.

### **To admit or not to admit? The dilemma with EUPD patients in crisis**

S was a patient in their early 20s whom I had seen in the middle of the night in the emergency department. They had been brought to A+E by staff at their supported accommodation due to them reporting suicidal thoughts and headbanging. They continued to headbang in A+E and had been referred for a Mental Health Act assessment. At one point it felt as though every staff member in the department was looking at me, as we could all hear the rhythmic thudding sound of headbanging in the nearby cubicle. Fresh in my mind was the recent Panorama BBC programme about Edenfield hospital in greater Manchester, which revealed the shocking way that patients were treated by staff. It seemed that a culture had developed in which staff had been drawn toward acting into the punishing, humiliating, victimising reciprocal roles. Without proper oversight, this toxic culture had been allowed to fester.

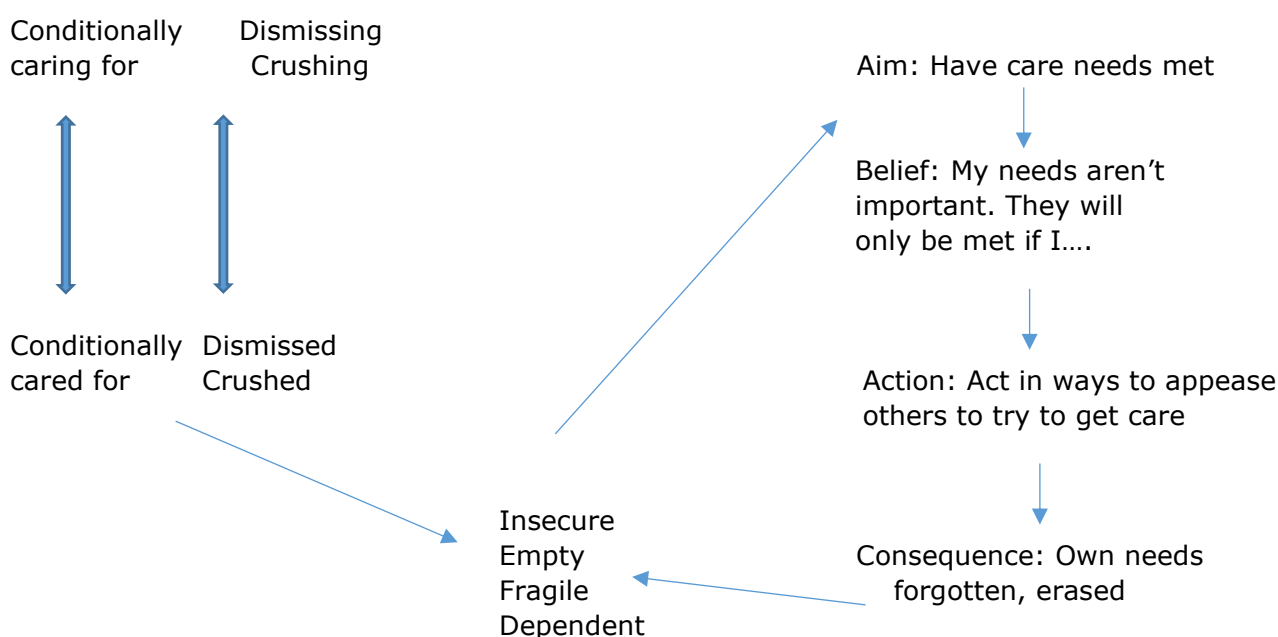
S had only recently been discharged from a secure adolescent unit after a four-year long admission, in which they were at times managed on a 2:1 basis (meaning 2 members of staff with the patient at all times due to the high risk of them self-harming). Reviewing documentation on S's extended care plan (a collaborative plan drawn up previously by the patient and their care team), I sought to model positive reciprocal roles – including listening/respecting to heard/respected in relation to the patient's

previously expressed wishes not to be admitted to hospital when in crisis. In doing so, I hoped to encourage them to emerge from the passive powerless role that they were so drawn to when in distress. In these situations, I now consider the roles I might be drawn into, and try to feel and name unmanageable feelings that may have been evoked in me. Was I being drawn into an 'ideally caring', 'rescuer' role by refusing to admit them, and saving them from my potentially abusive care? Was I in a 'punisher' role by denying them inpatient support, not knowing how to contain their distressing behaviour? The scaffolding of CAT helps me to reflect on these forces, allowing me to weigh up my decision in a more nuanced and balanced fashion, something that can be all too difficult in a hospital in the middle of the night.

### **How psychiatric care can replicate problematic reciprocal roles from a patient's past**

When psychiatrists are trained to follow a rigid structure which uses medical language, within an overwhelmingly biological understanding of mental illness, rather than the patient's own language of distress, so much can be lost or, as time goes on – *erased* as the patient gives up describing distress in their own terms, replacing their own intuitive understanding of their difficulties, with a wholly new narrative, leading to self-stigma and alienation. Wren Aves, quoted above, describes her experience of developing a 'paper-self,' a self that existed in medical notes, but overtook her 'real self' as she tried to meet the needs of staff in order to receive care, fearing that her 'real self' would be abandoned, and care would be withdrawn. The care that she received in psychiatric services seemed to reproduce harmful reciprocal roles that she had experienced in childhood: that she did not matter, and that she would have to placate others to receive care, losing herself in the process. I have constructed a partial SDR below to illustrate how the medical care served as a 'trap' which intensified unmanageable feelings and caused the patients mental health to deteriorate.

**Figure 2.**



When medical care triggers established reciprocal role patterns, the patient is again pushed into unmanageable distress, triggering a wide array of responses which may then be used as evidence that the patient still requires treatment, or is 'getting worse.'

For patients who have experienced abusive care, a response to these unmanageable feeling might be to flip into the top abusing role and become abusive to staff or other patients. In response they are likely be prescribed sedating drugs, which might be given forcibly by injection. This can have particularly troubling echoes for patients who have been victims of physical or sexual abuse in early life. As a CAT informed psychiatrist, I bring this awareness into my practice by ensuring that enforcing medication is an absolute last resort, when all other avenues have been explored (including an attempt at validation and containment of emotional states), and when there is a high risk of harm to the patient or the people around them.

### **The cost of forgetting, or perhaps avoiding politics**

To summarise, a conscious or unconscious denial of these political factors and their influence on a sense of mental wellbeing can have a significant impact on patients, as we replace their own interpretations of their struggles with a medicalised view that leaves them alienated and dependant on services. Consequences can also be far reaching at a policy level, as historical mental health reforms show. The Community Mental Health Care (CMHT) model introduced in the 1990s after the process of deinstitutionalisation has not shown significantly improved outcomes (Ikkos, 2018). Patients might be living 'freely' in the community, with a medical psychiatric framework of support, but if they are isolated, poor, unemployed, with limited access to services, how can we realistically expect their mental health to improve? Collectively the medicalisation of mental distress protects us from the fundamental unfairness and unjustifiableness of financial inequality, and in doing so punishes and alienates those living in poverty further, fostering a culture of dependence on services and medication.

This downplaying of political factors in mental distress does not just have consequences for the patient. The sense of ultimate responsibility for a person's safety that this puts upon the psychiatrist can be overwhelming. In '8 truths about suicide', psychiatrist Dr Rachel Gibbons talks openly about the devastating impact left by the deaths of patients in her care, and describes feeling 'deeply ashamed, humiliated, and alone.'

"My internal world was shattered and full of dread, and the mental health services I worked within were dominated by the fear of patients, perceived as carriers of 'risk' and defended against by risk assessments" (Gibbons, 2023).

Working under this kind of pressure is bound to evoke unmanageable feelings in consultant psychiatrists, with Target Problem Procedures likely to develop, impacting other staff and patients. In their paper "CAT as a model for the development of leadership skills" Mel Moss and Claire Tanner identified two patterns of behaviour in leadership styles of Consultant Psychiatrists that could be seen as a response to these unmanageable feelings. Firstly, they describe an 'autocratic' pattern, as seen in the Normansfield report, where the team consultant became increasingly controlling and domineering, resulting in a breakdown in relationships with other staff, as they felt the



need to either acquiesce or resist the demands of the consultant, whilst the needs of the patients were lost. Secondly, they describe a pattern of 'disengagement,' as described in the Staffordshire report, where the role of the consultant in mediating between clinical staff and hospital managers had been lost, leading to a disconnect that contributed to a culture of abusive care (Moss and Tanner 2023).

In early 2025, I will finish my medical training, and apply for jobs as a consultant psychiatrist, taking on a leadership role in the MDT. The self-awareness that I have learned through understanding my own counter-transference and developing my 'observing eye' during the CAT course will undoubtedly prove valuable to my leadership skills. It will help me to acknowledge and name unmanageable feelings that might arise in response to patients or difficult team dynamics and avoid veering into patterns of autocracy or disengagement occupying the top pole of unhealthy reciprocal roles, instead modelling healthier roles, bringing a balanced approach to issues within the team, allowing team members to feel heard and respected.

I have found the process of writing this article a valuable exercise in 'scaffolding' the concepts I have learnt in CAT onto my role in psychiatry. I have been observing and feeling in the top pole of 'self-self' reciprocal roles. Working in psychiatry I have always carried a complicated array of conflicting feelings, which I have not been able to give voice to at times. By thinking and feeling in a CAT framework, by turning my 'observing eye' towards them, I have become a better doctor.

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## The Diamond Framework: A Holistic Approach to Treating Emotionally Unstable Personality Disorders

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The Diamond Framework was created as a bespoke approach specifically to support individuals with a diagnosis of emotionally unstable personality disorder (EUPD) or complex trauma. This population of service users have usually experienced past abuse including sexual, psychological and physical abuse, neglect, loss and other hardships. Knightstone ward, Cygnet Kewstoke, had deteriorated in its therapeutic effectiveness; there was inconsistent messaging, a split team, a high number of self-harm incidents and poor engagement in therapeutic activities; the multidisciplinary team needed to radically change the ward culture in order to effectively support service users.

The Diamond Framework was developed to provide a robust structure for staff and service users and an environment that is psychologically informed, where all staff members provide psychological interventions to support service users and carers; this is achieved through skills coaching, consistent messaging, effective teamwork and co-production with service users. This holistic, person-centred approach empowers the service users to make informed decisions about their care, promoting responsibility and independence as well as facilitating personal growth.

### Key Components of Treatment Approaches and Guidelines

The holistic approach was grounded in best practice psychological theory for this population and included the incorporation of two established therapeutic models: Dialectical Behaviour Therapy (DBT) and Structured Clinical Management (SCM). Aspects of SCM on the ward included fostering compassionate and well-defined therapeutic interactions to model good relationships and developing problem solving skills (Bateman and Krawitz, 2013). A DBT programme was implemented to equip patients with skills to regulate emotions, manage distress and enhance relationships (Koerner, 2020). The teaching of DBT skills also extended to all staff in order for them to offer skills coaching around the clock. After a period of stabilisation, service users have the option to engage in trauma-focused therapy including eye movement desensitisation and reprocessing therapy (EMDR).

Building safety and trust are crucial elements with this framework and service users are supported through consistent messaging, professional language and time-limited, person-centred, structured 1:1s. This framework cultivated the validation of thoughts and feelings and curiosity when interacting with service users enabling them to become aware of internal mental states aiding autonomy, decision making and problem solving (Mitchell, Sampson & Bateman, 2022). During the intensive training to implement the framework, staff explored their own vulnerabilities and awareness of what they bring to

a relationship and gained insight into what motivates them to respond in a particular way.

Patients are involved in treatment planning from the start (Links et al., 2015) and short/long term goal setting is integral to the framework; there is a focus on the reduction of medication and using them only when necessary (Ingenhoven et al., 2018).

### **Observed Benefits**

The introduction of the Diamond Framework has led to improvements in care, satisfaction, outcomes and cost efficiency. The outcomes of implementing the framework far exceeded what was hoped for: self-harm monthly incidents decreased by 72% from 122 to 34. The holistic approach, tailored to each individual, helped service users develop skills and coping mechanisms to manage their emotions and behaviour. In addition, the number of restraints also reduced by 85% from 14 to 2 suggesting that the consistent, boundaried care provided has successfully prevented most potentially challenging situations, with restraint used only as a last resort.

There has also been an increase in service user participation in therapy sessions, especially the DBT groups (increased by 22%); they are using their DBT skills to cope with challenging thoughts and emotions between sessions with the support of all staff who are trained in these skills. Staff are facilitating structured, time limited 1:1s and are responding to service user needs in a consistent way. This results in more consistent, boundaried care with a positive impact on staff cohesion and a sense of ward community.

Service users report feeling more empowered and confident in managing their symptoms and believe it to be a result of the consistent and comprehensive approach of the framework. Before the Diamond Framework, the ward was running at a loss with only 6 people residing on the ward; since the implementation, the ward is full with a small waiting list. The framework has enhanced the care received, service user outcomes and staff cohesion.

### **Considerations and Aspects to Keep in Mind**

To prevent burnout, staff are offered weekly reflective practice and monthly CPD sessions to review skills, and challenges to the framework; this also supports their professional growth. The pressure to prevent violence and self-harm is mounting externally, with stakeholders often focus on incident rates and striving for zero occurrences (ref). Nonetheless no system can entirely eradicate risk; instead, we focus on lessening vulnerabilities through enhancing skills. We aim to measure achievements by looking at wellness indicators such as engagement in therapy, building relationships, reducing incidents and restraints, lowering the use of PRN/rapid tranquilization medication and finding positive coping strategies.

### **Reflections on Impact in Action**

For this to take effect, we needed to establish an environment characterised by consistent compassion and validation. An attitude of mutual curiosity was established amongst staff and service users, to foster both self-reflection and mentalizing the

behaviour of others, with the goal of enhanced self-awareness as well as a more compassionate outlook towards ourselves and others. We encourage all those who work on Knightstone to think dialectically, considering the question 'how much is too much, and how much is not enough?' with reference to contentious issues such as support after incidents and risk aversion. We seek to understand emotional vulnerability and distress as a complex relational phenomenon which can affect both staff and service users rather than situating these problems purely within individuals, as we strive for a person-centred, holistic ethos with a focus on empowerment and long-term positive outcomes for those we support.

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## Climate and Social Justice

### News from health climate activism

**Dr Marion Neffgen**

On behalf of the Faculty working group

We are in a planetary health emergency – signs of the escalating climate and nature collapse are all around us and in the news, if we can bear to pay attention and to stay with the troubles. The risks and consequences to the global climate, biodiversity and our societies have been spelt out by scientists, IPCC reports and campaigners in ever more direct and desperate ways ([world-scientists-climate-heating2024](#)).

We are faced with a multitude of threats to our social cohesion, our health systems, our ability to look after the most vulnerable in society, whilst confronted with increasingly divisive and extreme politics, further escalation of health and wealth inequality within the UK and between the global north and south, and an insecure and unpredictable future for the next generations.

If mother earth were a patient, she would be in intensive care, on life support and her family would be called.

You may wonder what this has to do with medical psychotherapy or psychiatry? Or what it is possible to do as just one person in the UK?

There are many good reasons to call this to our attention. Doctors and other health professionals have a trusted voice and a professional standing that cannot be easily dismissed. Doctors' voices have been instrumental in exposing the tobacco industry's campaigns, the risks of nuclear war and the AIDS pandemic. There are many other recent and historic examples, beautifully put together by a group of psychiatry trainees and psychiatrists in a 2022 publication [Protesting for public health: a case for medical activism during the climate crisis](#).

Moreover, climate action isn't good solely for the planet. The physical and mental health co-benefits are innumerable: better population health (including mental health), improved air quality, warmer/ better insulated homes, a healthier/ plant-based diet, and more access to green spaces and nature. And all these actions would reduce costs for the NHS. As importantly, engaging in climate activism is good for our own mental health and the best antidote to despair. [imperial-college/grantham-institute/Co-benefits-of-climate-change-mitigation-in-the-UK.pdf](#)

The following contributions aim to give an idea of how health professionals are getting



involved in different forms of climate, health and social activism, as well as to highlight successes, controversies, and some easy ways to take action.

But to answer the question about why we as psychotherapists should get involved, I would like to point to Judith Anderson's blog about the emotional toll of the climate crisis on young people. Anderson urges us, as adults,

parents, professionals, that "we cannot walk away from this". She calls for radical (realistic) hope and collective action to address the climate crisis, particularly from psychologically trained professionals who can offer their skills and knowledge around self-care and support, building resilience and creating containing spaces and communities.

We are all human and we all live in the messy real world. This is not easy. But as psychotherapists we know about defences, unconscious dynamics and the importance of facing and working through our feelings to be able to act with flexibility and coherence rather than responding reactively. In the light of all this, I would like to raise the following questions to all of us:



- What is the role of the medical profession in raising the alarm and awareness about the health and mental health risks of climate and ecological breakdown?
- What could medical psychotherapists and psychiatrists contribute?
- Do doctors have a moral duty to get involved more politically, if governments and institutions are failing us, and thus failing our patients and future generations?

### 1. Protest works! – ‘Drop Barclays’ campaign successes

The Royal College of Psychiatrists have agreed to move 95% of their money from Barclays to a different, more ethical bank - thanks to the sustained efforts of a small group of psychiatrists from the campaign group Psych Declares, and with support from the College’s sustainability champions, different divisions and faculties (including the Medical Psychotherapy Faculty exec), as well as many individual college members who signed the petition. Thank you all!

Similarly, the BMJ has recently committed to banning advertising from fossil fuel companies and the banks who fund them:

<https://www.bmj.com/content/bmj/387/bmj.g2197.full.pdf>, following months of pressure from doctors angry at the BMJ running Barclays advertising in one of the world's leading medical journals.

(As a reminder, Barclays is Europe’s biggest fossil fuel financier, at \$24.2bn since the Paris Climate Agreement. [theguardian.com/banks-almost-7tn-fossil-fuel-firms-paris-deal-report](https://theguardian.com/banks-almost-7tn-fossil-fuel-firms-paris-deal-report))

Barclays and other banks have also come under further pressure from campaigners, charities and organisations because they are implicated in profiting from and facilitating the ongoing genocide in Gaza. <https://caat.org.uk/publications/barclays-arming-israel/>

For more information, check out the Bank Better movement.

<https://bankbetter.uk/about/>

**Recommended action:** To find out about your bank’s climate impacts, and to move your personal bank account to a more ethical bank, please check <https://bank.green/>

### 2. The Climate and Nature (CAN) Bill is back in parliament

The CAN Bill is the only proposed legislation before the UK Parliament that ensures a comprehensive and joined-up approach to the emergency, and to safeguard that policy and action on the climate crisis are science-led and people-oriented. The Bill, which was written by scientists, experts and campaigners, now has the backing of 216 MPs and Peers representing all major political parties. <https://action.zerohour.uk/>

**Recommended action:** Please spend a few minutes to write to your MP to support the CAN bill. There’s a template to help on the website - it’s really easy!

### 3. ‘Plant-Based by Default’ food menu campaign

Plants First Healthcare Campaign, a coalition of over 20 supporting organisations, and signed by more than 1000 health professionals, are calling for plant-based meals to be the default in healthcare settings. They state: "There is now overwhelming evidence that shifting towards a plant-predominant food system can significantly improve national health outcomes, address health inequalities and is essential for meeting our climate and nature targets. There is growing evidence that it could also decrease NHS costs. '*Plant-Based by Default*' menus offer and incentivise plant-based meals as the primary menu option without restricting choice – meat and other animal products remain on the menu."

The negative impacts of animal agriculture on climate and nature are huge (accounting for around 25% of global greenhouse gas emissions), and the health benefits of plant-based diets (planetary health diet) are equally huge.

You can read more about it on their website or in this article [The Independent/hospital-food-tim-spector-health-vegan-plant-b2628101.html](https://the-independent.com/archive/food-tim-spector-health-vegan-plant-b2628101.html)

**Recommended action:** Please send the template email to your trust and NHS England. <https://plantsfirsthealthcare.com/take-action/>

#### **4. Under the weather - the emotional toll of climate change (especially on young people)**

Judith Anderson, former chair of the Climate Psychology Alliance, Jungian Psychoanalyst and psychotherapist, writes in a blog for the RSA about "the emotional toll of climate change, particularly on younger generations".

<https://www.thersa.org/rsa-journal/2024/issue-3/under-the-weather-climate-psychology>

Anderson emphasises the fears, anxieties and isolation they might feel when dismissed by older generations, quoting a UNICEF report naming it a "children's rights crisis". She stresses that dismissing or ignoring young people's justified concerns, together with the awareness of inadequate/ repressive government action (symbolising parental neglect and abuse), causes moral injury and contributes to the emotional burden of knowing their futures have been stolen. This is what psychoanalyst Sally Weintrobe who spoke at our Faculty conference in 2021 termed the "culture of uncare". Anderson also points to increasing violence against environmental protesters globally, including against young people, and police violence not only in South America where this is particularly frequent, but also in Europe.

Anderson suggests that older generations and parents have something to offer - empathy, validation, and engagement with the problem, as well as support for their actions. She urges that "we cannot walk away from this" and advocates for building a "generation of psychological professionals who are educated about the psychological impacts of climate change and trained in how to work with these, both inside and outside the consulting room". She calls for radical (realistic) hope, collective action and building resilience to address the climate crisis.



**Recommended Action:** <https://www.amnesty.org.uk/actions/scrap-anti-protest-laws>

## 5. Doctors involved in environmental and social protests

The BMJ recently published a head-to-head debate discussing "Should doctors be suspended for breaking the law?" <https://www.bmj.com/content/387/bmj.q1888>

This piece relates to the recent suspension of GP Dr Sarah Benn by the MPTS for 'professional misconduct', after being given custodial sentences for peaceful environmental protest. It is well worth a read and a think about.

A question raised by a young trainee at the end of our last faculty conference in Leeds is still ringing in my ear. She remarked that she was stunned that the destruction in Gaza had not been mentioned at the conference, and asked: If we can't speak about the conflict and the horrors inflicted on people in Palestine (during a conference about Power, Conflict and Leadership), where does that leave us as human beings?

**Recommended action:** If you want to find out more about what health workers are doing in relation to the crisis in Palestine, please check out *Health Workers for Palestine*, organised by Medact, with easy ways to support and take action <https://www.medact.org/project/health-workers-for-palestine/>

## 6. Update on the state of the climate and nature emergency

If you think I'm exaggerating the state of the climate emergency, please have a look at the following resources:

[earth-breach-planetary-boundaries-health-check-oceans](#)

[global-water-crisis-food-production-at-risk](#)

[nature-carbon-sink-collapse-global-heating-models-emissions-targets-evidence-aoe](#)

Johan Rockstroem (Potsdam Institute for Climate Impact Research) on **The Double Crisis: Climate & Biodiversity (September 2024)** <https://youtu.be/5d-UqYrCcgo?si=v7I2n4GNNmSFW8SG>

[UqYrCcgo?si=v7I2n4GNNmSFW8SG](#)

<https://www.hurstpublishers.com/book/sorry-for-the-inconvenience-but-this-is-an-emergency/>

Dr Lynne Jones, a child psychiatrist working with the WHO and UNICEF author of the book "Sorry for the inconvenience, this is an emergency", with Dr Fiona Godlee, former editor of the BMJ on the effectiveness of non-violent resistance & the role of trusted health professionals.

<https://podcasts.apple.com/gb/podcast/afterwords/id1499818185?i=1000674960684>

A 30-minute listen, an illuminating conversation between Lynne & Fiona

## Trainee Voices

### Introduction from the Editors of Trainee Voices

**Dr Hafeesa Sameem**

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**Dr Eleanor Riley**

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Welcome to "Trainee Voices", Autumn 2024.



As we whizz through the second half of the year, I think it is important to pause for a moment and just take in the beauty of the fall season. I don't think Autumn gets enough credit as it's often met with irk at the end of summer and the anticipation of the dreaded winter, the only saving grace being the upcoming festivals. Though I must say we didn't have much of a summer to most of our chagrin! But, as always Autumn reminds us of how change is the most constant thing in life so we shouldn't make letting go hard.



Now that I am done romanticising Autumn, I will go on to compliment our trainees for the wonderful creations that have been sent in for this column. We had quite a varied and interesting mix of submissions this time. From a simple yet powerful ode to psychodynamic interpretations arising during psychotherapy sessions to reflections on focusing on any one thing - even something as primal and distasteful as fear, to handle challenging emotions. We have submissions exploring the evergreen topic of

the impact of Attachment theory and past trauma on the patient's relationship with the psychiatrist to one that shifts the lens onto the psychotherapist and their struggles with ambiguity and need for a healthy relationship with their supervisors. Our attention is also drawn to the quintessential struggle of figuring out where and what "Home" is for our International Medical Graduate doctors who are an important part of the backbone of NHS. And finally, an interesting peek into two experiences of CBT and "Human Givens Therapy".

Thank you to the trainees who have contributed to the voices heard in this section; hopefully you will find the articles insightful.

We would like to welcome submissions from others on their training journeys in the form of reflections, commentaries, reviews, art or poetry that can be gathered for the next Spring Newsletter.

## Something About Fear

**Dr Adam Boggon**

CT2 Psychiatry, East London NHS Foundation



Ruminating pointlessly over the minutiae of a lost relationship, I trudged up a slope of broken rock in the Schwyzer Alps. The route was Cameron's choice. My brother had defended his PhD thesis in Zürich two days prior and this was his chosen celebration.

We reached the foot of the climb and slipped into harnesses, donned helmets, double-checked karabiners, and clipped onto the first length of the fixed cable.

Iron pins and hand hooks had been hammered into a route on the Dachstein in Austria in 1843 and experiments proceeded from there. Permanent lines were fixed in the Dolomites through World War I to permit soldiers passage across mountain faces in harsh conditions.

Steel cables and metal rungs have since replaced ropes and wooden ladders. Mostly courses feel safe, like scrambling with stabilisers on.

That morning the rock was wet. Swiss 'via ferrata' routes place fewer holds than elsewhere in the Alps, leaving climbers to rely on rock rather than metalwork for grip. This is one thing in the dry, but we climbed inside a cloud over wet rock, and I wore black running shoes so flimsy they resembled plimsoles. Within minutes I slipped and cut my knee on the gneiss. My blood mixed with water on the rock.

I wondered why I was finding it so tricky. I was out of practice, sure, but had grown up crossing Highland ridges and climbed via ferrata routes around Cortina and Annecy without much trouble. Cameron explained halfway up that our route was rated K5, meaning '*very difficult... only suitable for experienced and highly skilled climbers... long exposure to heights*'.

I can confirm the definition. Within the first pitches I became conscious that my legs were shaking. It was a rattling, involuntary, twitch-tremble-never-rest type of shake. I could climb, but it didn't feel great. Higher up on an especially long overhung section with a lot of air beneath me I felt my strength fade. My pulse quickened. I began to hyperventilate. Had the cliff been then a mirror I would have seen my pupils dilate and my face blanche. I was afraid.

I knew on one level that were I to slip, the harness and karabiners would keep me on the wire. The shock absorber would deploy, my fall would be caught and slowed. Then I would slam into the wall. This part concerned me because all the rungs and spikes which I had used to scale the cliff would in a moment become cudgels and bayonets. I looked up but couldn't see where I was going because of the overhang and the mist. All I was sure of was that I couldn't down-climb the section we'd ascended.

To be cragfast is to be stuck on a mountain feeling able neither to ascend nor to descend. It is an awful sensation of being stuck in a frightening place – a trapped-ness. I wasn't there yet, but my breath quickened again, and I veered toward panic.

Recognising the brink, I began to do sensible things. I clipped a third karabiner on a length of fixed cord to a rung, taking the weight off my arms. I pressed my forehead against the cold of the rock. I listened to the cowbells echoing up the wall from the meadow far below. I focused on my breathing *In, hold, out-two-three-four*.

Five breaths and my mind began to clear. Lactic acid ebbed from my arms. My legs settled. I knew I was fine. Best of all, the rest of it had washed out with the fear: vain anger, bootless grief, futile regret. I was present in my circumstances. I pulled myself over the nose and climbed past the overhang. I would get there.

There are many ways to be ok. There is a time to sit with ourselves, to listen and be kind to whatever comes. There is a time to cross our arms over our shoulders and tell ourselves it will be alright. There is also a time for fear, for realising like the family in Michael Rosen's *We're Going on a Bear Hunt* that we have to go through it.

Fear draws us out of ourselves. The feeling I had on the rock was only a stronger expression of the anxiety-dread-excitement I have felt many times in the changing room before a football match, upon rising for a debate, arriving at a cardiac arrest, or asking someone out. Fear experienced briefly brings focus, a falling away of other noise, even a kind of sweetness. On Eggstock, fear drew all my senses to the angle of my knee, to my brother's encouragement, to the metallic taste in my mouth, to the smooth, cool rock.

I thought of a girl I see in clinic. When the stress in her life swells it looms over her head like a wave and crashes. She shuts down. She stops speaking to her mum or replying to her friends. She goes to her room and from a hidden place takes a razor. She cuts a line in the skin across her upper thigh. The act requires total focus. Through it, somehow, her desperation washes out.

Huddled with my brothers in a crevice in the face above the overhang I considered that although I had sat with her for hours, I may only now have an inkling of her experience when she cuts – the panic, the focus, the release. I wondered if perhaps to reroute this defence against overwhelm she would need something beyond grounding exercises and compassion for herself. Perhaps she needed a way to get out of her head. Perhaps on a bouldering wall or a basketball court or within a choir or on a tightrope she could zero-in and be made safe through complete attention.

From the top we slithered and slipped down the steep reaches of rock, achieved the path which traversed the mountain, and began to run. We were tight for time to make the last chairlift. I was entirely there.

## A Trainee's musings of Psychotherapy

**Dr Harshani Yapa Bandara**

CT2 in Psychiatry, Northamptonshire Healthcare Foundation NHS Trust

When I reflect on my experience of psychotherapy, the uncertainty and the resultant frustration that comes bouncing happily along with it, is all encompassing. A consultant once said, "I feel this patient is really well suited for you". How do you know – the question scratches the back of my throat. How does someone know me well enough to say this? We show only so much of ourselves as we feel is acceptable. As far as the proposed patient goes, all we have is a clinical record, and the writings of others. No matter how hard and how in depth we scour this record, we can only ever know that which we "seem" to know. We know things not as they are but as we consciously or subconsciously wish them to be. And to an anxious trainee like me, this is frightening. It means the path ahead may not be as steady as it appears.

Being an IMG, the fear of doing the wrong thing weighs especially heavy amidst all the other fears swimming around in my head. What if despite all my best intentions, my patient's mental state deteriorates? What if some innocuous sentence that slips out of my mouth sets her on a crash course to catastrophe? Like watching a train, slowly chugging away from the train station, will I stand frozen on the platform, unable to change its course? And then what will happen to me? I can envision being sat on a chair, amidst a crowd of curious, suspicious eyes, all asking the same question: "How could you do this?"

I listen to this woman speak, seated in front of me. She paints a picture of a young girl, traumatised in one way or another, of hurts that go unnoticed by the adults around her. The things that happened to her, these are all incredibly difficult to hear. Difficult to imagine. Beyond difficult to experience. And here she sits, making frantic attempts to drag herself out of the abyss her childhood has dragged her into. It's hard to remain neutral. It feels wrong to remain neutral; should I not be showing her that I am in her corner, in clearer terms? That I will take up arms, because I can see how wrong it was? There is anger in the room; some of it comes from her, thinking of all the million ways she was failed. The rest is from me, also thinking of all the million ways in which she was failed. The unfairness of it all. The imaginary line that divides her side of the clinic room, from mine, looks at me curiously. I do not know how to cross it.

Her experiences have led her on a path leading to a distorted, untrue thought that now lies at the core of her being. "I am broken". She has other iterations of this thought. "I am too much, I am damaged, too difficult. I deserve this." The sneaky, ever-present voice, in the back of her head speaks beguilingly – "You are not enough. You are too much, and Your emotions are too much."

We sit opposing each other, and I walk her through mindfulness exercises and ways of using meditation as a form of relaxation. I tell her only to acknowledge her thoughts, but not to follow them down the rabbit hole. We talk about journalling, hoping that putting her thoughts down on paper, will finally free her mind of them. While I do this, my own inner self is frantically wondering how such trivial things can hope to dent the colossus that this woman's negative schemas have become. We use the 3-chair technique, which often results in bringing the sadness hidden deep within her to the surface. She tells me "I wish someone had shown this compassion to that younger version of me. If they had only looked, couldn't they have seen how obviously hurt I was?"

She is always dressed in black, the colour matching her hair, and a perfect foil for the paleness of her skin; a well put together hopeful young face. There is a calmness that fills the space when she speaks. She speaks of the derogatory hateful self-speech she engages in, and slowly all her other secrets come tumbling out. Always at the end, I walk away carrying her inner thoughts sloshing around in my own head. If my writing feels disjointed, then it reflects how I often feel – exactly that. My brain flip-flops from her sadness to my anxieties, and ricochets off everything else that is there in-between. It is clear to me; I must find some way to throw out a branch for her to latch on to.

I tell her she needs to be kinder to herself. I tell her she must practice this self-compassion, like a musician practices his instrument – religiously. I tell her to envision herself as the ideal compassionate being, and I tell her to direct this compassion like a laser beam on herself. And yet, the question remains, if she has had no one to model compassion for her, how well can she envision this for herself? I am not sure. How well do you know kindness when it has only been a fleeting visitor in your life?

These narratives of past hurts are the narratives of many of our patients. We seem to have an unending capacity to hurt ourselves and others, an army of impaired adults that march through the doors of various Community and Inpatient mental health teams, looking for ways to fix themselves. Whether this cure will be gifted to all, remains to be seen.

In the end, I am resigned to believe that my questions and my worries will never really disappear in whole. And perhaps that is how it should be; so that I am constantly on the lookout for things I might miss. Perhaps the business of psychotherapy is about managing our own fears and distorted cognitions alongside those of our patient. I am not sure. I don't have the answer. I don't think I ever will, and despite this, the world will continue to turn, I am sure.



## Exploring the Transformative Journey: Insights from my Psychotherapy Case

**Dr Faquiha Muhammad**

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Mrs X is 78 years old, and on the surface, lives an idyllic life, on an old stonework farm, surrounded by a multitude of happy wagging tails and the quiet kindness of farm animals contentedly munching away on lush green grass.

But all is not as it seems. Mrs X is worried. She worries about the possible machinations of her sister, who also lives on a nearby farm and is convinced Mrs X is not able to look after her own inheritance and is trying to convince her to sell it. No, she will sell it for her. Mrs X worries about keeping her husband happy; she is never busy enough, or active enough for his liking. Perhaps she could sleep less, waking up earlier to do chores around the house. Perhaps she should sit around idly far less often, reading novels. She worries she is becoming more forgetful; perhaps she has Alzheimer's? Mrs X remembers looking after her mother when she was diagnosed with this dreaded disease. She doesn't want that for herself. Her worries keep her restricted to a little life hemmed in by this worry and that. It is a far cry from how she imagined her mellower years would be.

Mrs X has been labelled with a diagnosis of Mixed Anxiety and Depressive Disorder. The abbreviation itself is telling, MADD. There were queries of Dementia. Medications had been prescribed. And still, she worries.

She does not leave her house much. She does not go out to the women's club meetings. She just is. A former mental health nurse, who fearlessly worked night shifts, with a large group of co-workers akin to family, she is no longer the woman she used to be. The younger Mrs X had a home filled by the frequent visits of friends and work colleagues, with their laughter and witty conversation; visits which were often questioned by her husband "do you ladies have nothing better to do, than sit here chit-chatting?"

In working with Mrs X, the question arises – how does she see herself? She sees a woman easily led by others, and this feeds into her fears of her sister manipulating her. Her sister has dominated her decisions all her life thus far, so why should this be any different? She sees herself as the captain of a ship named "Responsibility" and there are no first mates nor others to delegate her burdens to. And she is weighed down by her guilt. She feels perhaps it is her sister's and her husband's right to make decisions for her. She thinks she cannot ask favours of others – she would be imposing on them. Her children are grown adults, and still, she hesitates to share responsibility with them. She drives around with her husband on his errands, because he worries that he may not be able to communicate well on his own. So, Mrs X sits there patiently waiting, to be called on to be his voice.

And her previous experiences of sharing her fears with others have backfired on her painfully. "You're becoming paranoid" they said. "It is only your Anxiety". She began to



believe that perhaps she was creating her fears and worries in her own mind. Perhaps she really was losing her mind, much like her mother before her. It was inevitable then that she would tire of trying to convince those around that her fears may have some grounding in truth and reality.

In the course of our therapy, it becomes clear that Mrs X is a lady who feels dismissed and unheard. While our sessions work through the usual well-known steps of Cognitive Behavioural Therapy, in the end what I can give her is something no one else had given her thus far in her life, and illness: an attentive ear, and ample time to vent her frustrations. In retrospect, our sessions together brought some validation to her. She worked actively on assertiveness, and learned to let go of the need to prioritize the happiness of others above her own. She learned to be her own advocate; her family appears to have learned too, the negative impact of their dismissiveness.

At the conclusion of our sessions, Mrs X invited me out to her farm. I visited her on a warm summer's day, where I finally saw Mrs X as she used to be; the assured, resilient older lady who had weathered her storms.

## Psychotherapy supervision: A world behind words

**Dr Kyrillos Meshreky**

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The few moments of awkward silence at the beginning of psychotherapy group supervision are very well-known to most therapists. The supervisor waits patiently for group members to bring a case for discussion. Group members get in a deep-thinking state, in a moment of choice: shall I spill the beans about this patient who disappeared after the first session? Speak about it now or forever hold my peace?

This moment of silence carries infinite possibilities for the group, countless paths that the group may take, numerous ideas and emotional experiences awaiting group members. Like Schrodinger's sealed box in his famous thought experiment, the answer is unknown until the box is opened.

Then someone breaks the silence and brings a case for discussion, while the room listens attentively. The supervisor, like a wise Gandalf, makes split-second decisions about whether to probe or not, whether to share with his supervisees the experience he painfully gained throughout his years, or rather step back and observe how the group's collective consciousness will flow in a mystical dance.

A psychotherapy session too carries infinite paths that will be shaped by the therapist's and patient's instantaneous decisions. Such decisions are mostly controlled by unconscious drives. The therapy session is like an ocean of possibilities in which the therapist deep dives with his patient, trying to weigh his words, emotions and even silent pauses. However, in this process of weighing, the weight is not so much in the words as in the unconscious drives behind them. A hard-working therapist tries to

decipher the unconscious world behind the patient's words. The more experienced therapist tries, as well, to decipher snippets of his own unconscious; questioning his words and what could possibly be driving them before uttering them to the patient. In doing so, the therapist becomes slightly more aware of his internal world and embarks on a journey, not only to understand the patient, but also to explore his own hidden fears, conflicts and biases, in a humble search of genuine acceptance of some of the most difficult human complexities.

In medical training ambiguity is not well tolerated, and most questions have a single best answer. In contrast, ambiguity rules in psychotherapy, acceptance is an effective tool and silence is as valued as the wisest of words. Sometimes as trainees we wish our supervisors could "tell us what to do", give us shiny clear answers straightaway or walk us through the door of secret psychological phenomena. In contrast, they ask questions about what the patient looked like or where he/she was born or how his/her childhood was. We often struggle to understand the reasoning behind these questions. Perhaps it is a way to assess how well you know your patient or perhaps it is a way to assess how well you know yourself - your biases, prejudices and projections? This inner world of yours will shape the lens through which you see your patient, will carve a therapeutic relationship where corrective relational experiences give a slow birth to unconscious healing. Hence, it makes sense that supervisors would not have all the answers. Instead, they become mirroring safe spaces for supervisees, to guide their little journey beneath the surface of consciousness and reasoning, the journey to the world behind words.

## Home for an Immigrant Doctor- an elusive concept

**Dr Shehroz Shakeel**

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The United Kingdom's National Health Service (NHS) has long been a beacon for skilled medical professionals from across the globe, particularly for immigrant doctors seeking world-class training and career advancement. According to the General Medical Council (GMC), over 30% of doctors practicing in the NHS are foreign-trained, and this number continues to rise annually. Many come to the UK with hopes of enhancing their professional abilities while simultaneously securing a more prosperous future for themselves and their families. The NHS, facing chronic staff shortages, relies heavily on these doctors, who contribute significantly to the functioning of the health system. Yet, while their presence is critical to healthcare, the journey for these immigrant doctors is fraught with emotional, professional, and cultural challenges, often leaving them in search of what truly defines "home."

For immigrant doctors, the initial excitement of securing a job abroad is often met with the harsh realities of adjusting to a new healthcare system and workplace culture. Though the NHS provides them with unparalleled opportunities for training and development, the transition can be daunting. Many find themselves grappling with

regulatory requirements, new medical protocols, and unfamiliar administrative systems. The pressures are intensified by the need to consistently prove competence, often working longer hours in high-stress environments.

While the NHS is widely recognized for promoting diversity, acceptance, and inclusion, and actively supports foreign doctors with various programs and training, adapting to the new system still requires a steep learning curve. Immigrant peer groups within the NHS and the broader medical community play an important role in helping doctors connect with one another, providing support, and organizing events where doctors from different cultural backgrounds can meet. These events often take place during significant cultural or religious occasions, offering a sense of home to those far from their native lands. Despite these support systems, many immigrant doctors still face the challenges of adjusting to a new culture and environment.

Beyond the professional struggles, immigrant doctors also face deep emotional challenges. For many, moving to the UK means leaving behind not only their countries of origin but also their families, friends, and cultural roots. While the NHS does make an effort to ensure that immigrant doctors feel included through social events and support groups, it is difficult to replicate the sense of comfort that comes from familiar faces, places, and traditions. The shared moments of celebration, familial support during hardships, and the deep sense of belonging that stems from being surrounded by loved ones cannot easily be replaced by even the most well-intentioned support systems.

Many doctors come to ask themselves the difficult question: what is “home”? Though they live, work, and try to integrate into the UK, they may never feel entirely at home. Despite the cultural acceptance and the warmth offered by their peers, something often feels missing—the familiar rhythms, languages, and unspoken understanding that come with one’s native environment. Even after years of living abroad, many immigrant doctors remain outsiders, never fully able to call their new country “home.”

At the same time, when they visit their native countries, they do so as guests. The places they once called home have changed, and so have they. No longer fully fitting into their original cultural and social fabric, they feel the dissonance of being both an insider and an outsider. They straddle two worlds, neither fully belonging to the one they left nor the one they have moved to. This duality creates an emotional limbo where “home” becomes an elusive concept, split between two distant realities.

While immigrant doctors are often viewed by those back home as successful and fortunate for having secured a life abroad, the truth is far more complex. There is a widespread misconception that living and working abroad automatically equates to an easy, prosperous life. Many fail to see the immense sacrifice involved in leaving everything familiar behind. The longing for familial bonds, the struggle to integrate into a new culture, and the constant search for a place to belong are all part of the emotional price they pay.

Doctors, often the primary breadwinners for extended families back home, must come to terms with the fact that while they have improved their economic standing, they have

paid a heavy toll in emotional wellbeing. The feeling of isolation, the struggle to forge new social bonds, and the inability to attend significant family events in their home countries contribute to a deep sense of loss. Even though they are able to return home occasionally, they feel like visitors, and their place in the family dynamic has shifted in subtle, and sometimes painful, ways.

Despite the many struggles immigrant doctors face, both the NHS and broader UK society can be helpful in easing this transition. The NHS is particularly committed to promoting diversity and inclusion. It acknowledges the cultural backgrounds of its doctors and actively works to make them feel welcome. Peer support networks within the NHS provide spaces for immigrant doctors to connect, offering solidarity and understanding. These groups organize events and gatherings during significant cultural and religious holidays, so immigrant doctors don't feel entirely removed from the traditions of their homelands. Such initiatives go a long way in fostering a sense of community, even when miles away from home.

Beyond institutional efforts, society at large must continue to evolve in its attitudes towards diversity and multiculturalism. Accepting immigrants is not enough—there needs to be an active effort to integrate them into the social fabric, to create spaces where their unique identities are not only accepted but celebrated. This is how true belonging is fostered, ensuring that immigrant doctors can feel at home not only within the walls of the hospital but within the communities where they live.

## Human Givens Therapy: A Holistic Approach to Mental Health

**Dr Hannah Liu**

ST6 General Adult Psychiatry, Birmingham & Solihull Mental Health Foundation Trust

I first encountered the Human Givens approach when I picked up *Human Givens: The New Approach to Emotional Health and Clear Thinking* by Ivan Tyrrell and Joe Griffin. The book was engaging, insightful, informative and filled with remarkable anecdotes about treating a range of mental health disorders, including depression, anxiety, and psychosis. As a psychiatrist, I was naturally sceptical, especially since this approach had not been adopted by any of my colleagues. However, much of the theory resonated with me, and my curiosity was piqued.

In a society that often emphasizes material success and individual achievement, the human experience is frequently reduced to external markers of status and accomplishment. Yet, true well-being lies in meeting our innate emotional needs, such as security, connection, autonomy, and purpose. These core needs have been explored by various researchers, from Maslow's hierarchy to Max-Neef's Human Scale Development and Burton's Human Needs Theory. Despite this, mainstream mental health interventions frequently overlook these fundamental elements, leaving many underlying causes of distress unaddressed.

Intrigued by these ideas, I decided to learn more and eventually completed the Human Givens Diploma. The Human Givens approach, developed by Joe Griffin and Ivan Tyrrell, integrates concepts from various schools of psychotherapy. At its core is the belief that humans have essential emotional and physical needs—referred to as “givens.” When these needs are met appropriately, individuals can live mentally healthy and fulfilling lives, regardless of their circumstances or cultural background.

The key emotional needs identified by the Human Givens framework include:

- Security
- Attention (both giving and receiving)
- A sense of autonomy and control
- Emotional connection with others
- Feeling part of a wider community
- Friendship/intimacy
- Privacy
- Status within social groups
- Competence and achievement
- Meaning and purpose

The therapy borrows techniques from Cognitive Behavioural Therapy (CBT), Solution-Focused Therapy, Neuro-linguistic Programming (NLP), guided imagery, and relaxation exercises, creating a holistic approach to mental health care.

What I found most fascinating about the course was the integrative approach to managing mental health disorders. By recognising both emotional needs and inherent resources, the Human Givens model promotes a human-centred approach that focuses on empowerment by encouraging individuals to take an active role in their own recovery. This is something I found lacking in traditional psychiatric training, which often prioritises medication over patient autonomy.

I recall one patient who was referred by his GP for "anger issues" and a possible diagnosis of dissocial personality disorder. He had been suffering from low mood for years, despite trying various antidepressants. He recounted an incident from years ago when, as a security guard, he was injured while apprehending a shoplifter and subsequently lost his job. He described how "things always end this way" for him and how life seemed stacked against him.

It was only after completing my Human Givens training that I began to wonder if his anger was, in fact, misplaced anxiety rooted in trauma from that incident. Though he was hesitant about psychology, I persuaded him to try the "rewind technique," a key method in the Human Givens approach that helps neutralise emotionally charged traumatic memories. The effect was remarkable. At his next appointment, he was visibly brighter, less angry at the world, and even spoke about visiting the job centre to look for work. Over two more follow-up sessions, I made no changes to his medication, and though he still had frustrations, his irritability had diminished.

While my personal experience with the Human Givens approach has been overwhelmingly positive, it is important to acknowledge that it has not yet gained widespread acceptance. This is largely due to a relative lack of empirical research compared to more established therapies like CBT or psychodynamic approaches. However, the anecdotal successes I've witnessed, and the holistic, integrative nature of Human Givens therapy strongly suggest that it holds great promise.

I believe there is a real need for further research into the efficacy of this approach, particularly given its focus on addressing the root causes of distress through innate human needs. In an era where mental health services are increasingly stretched and patients are often given quick, surface-level solutions, the Human Givens approach offers a refreshing alternative that encourages patients to take control of their well-being in a meaningful way.

For those open to exploring new paradigms, Human Givens therapy may offer a valuable toolkit for empowering individuals to regain control of their lives and rediscover a sense of purpose. I encourage clinicians and researchers alike to consider integrating its principles into broader practice, contributing to a future where mental health care is more human-centred, holistic, and effective.

### **Recommended Reading:**

Griffin, J., & Tyrrell, I. (2003). *Human Givens: The New Approach to Emotional Health and Clear Thinking*. HG Publishing, East Sussex.

## **The Importance of the Past and Attachment Theory for Our Patients on the General Psychiatry Wards**

**Dr Mahesan Murugavel**

CT2, Leicestershire Partnership NHS Trust, East Midlands Deanery

The work of Mary Ainsworth and John Bowlby on Attachment Theory has been seen as increasingly important as we consider the attachment of our patients to their primary caregivers (e.g. parent) and how this can affect future relationships. This link to the past has been something which psychodynamic therapists have long been familiar with. What about General Psychiatrists? Do they appreciate its importance?

Past abuse/trauma can result in patients having CPTSD or a Personality disorder. General Psychiatrists often manage them with medications on the wards - benzodiazepines, Quetiapine, antidepressants. Sometimes these help. At other times they can harm patients with side effects, and with false hope that wounds from the past, can be healed by tablets. The observation of patients with a history of abandonment (loss of a parent through bereavement, prison, incubator baby, parental separation etc) is heavily linked to an insecure attachment style. It has an enormous effect on future relationships.

For patients with a disorganised attachment style (an insecure attachment style, common in CPTSD or a Personality disorder) there can be a push/pull dynamic. Projecting their past relationship of their primary carer onto to their consultant can

result in them being clingy, wanting a long admission, or angry, storming out of the room during ward round. It is important to take these attachment patterns into account when planning treatment.

Psychiatry seems to embrace the science of pharmacology and tablets and to have forgotten Trauma. That the past is stored in the amygdala of the brain. Children know that their caregiver is essential for their survival. No young child can go to work, do their shopping, cooking, pay the gas and electric. This fear is stored in their amygdala. When the Consultant mentions discharge, the past and present combine. The feeling of abandonment resurfaces, and the trauma response/memory stored in the amygdala activates the HPA (hypothalamus – pituitary - adrenal) axis. The adrenal gland surge of adrenaline causes the fight and flight response. Palpitations and hyperventilation may occur. The patient's terror may cause them to self-harm or to storm out of the room only to rush back a few minutes later asking to remain an inpatient.

If we are aware of their past, we can make better discharge plans that feel more containing. Their discharge date could be a collaboration, agreed with them. To give them the control they never had in their past.

The effect of the past is not the monopoly of Psychodynamic psychotherapy. It affects all psychiatrists and let us embrace it, so that our patients have the best outcomes.

## "The First"

**Dr Giancarlo Novani**

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Autumn is my favourite season. It is a time of change when the oppressive daylight hours come to an end, and you reap the long-awaited fruits of its constancy. Where I live there are wild cherries, apples, berries, wild mushrooms and a plethora of trees aflame with embers of the summer. I enjoy picking the fruit, savouring it and in some small way connecting with the circadian rhythm of mother earth. My children enjoy the novelty of it all. It is a minor Christmas each time one of them happens upon a nest of berries ripe for digestion. I am very much alongside them as they celebrate the preamble to Halloween and watch patiently as darkness moves as gently as a kiss and slowly extends its fingers into the morning and evening.

One of the many things I like about this transitional state of the earth is just this. As autumn goes on, we see many things shed their leaves, perhaps even die. This is one of the fruitful things about therapy. Letting go of that which will not be carried forward into rebirth. And for rebirth to occur, in a meaningful way, one must first embrace the darkness of death before the light can prevail.

Many have used such metaphors, but Carl Jung is the person whose work I am most familiar with when it comes to embracing the shadow in the process of growth. The fictional character whom I would like to speak of is someone many of my generation will closely associate with this time of year: Buffy the Vampire Slayer. Without guilt,



shame or any other feeling tied to not wishing to reveal how much I loved (and still love) this show, I would like to bring into this piece of writing an episode which I think sums this idea up quite nicely.

As most, or perhaps even all of us know, vampires are known for their need to consume human blood as sustenance. In the show, they are soulless creatures who kill humans without remorse so that they may live eternally. Many are particularly cruel and take great pleasure in the torment they inflict upon the human race. Provided they are not killed, the vampire will run beyond the grip of time, viciously and gleefully ending innocent lives.

The show ran for many seasons and this episode takes place later in the story arc. Up to this point Buffy would often patrol her locale, sifting through the possible locations a vampire may be lurking and turn it to dust with her trusty stake. It was something she did reluctantly, almost bitterly, because while she was sinking wood into the heart of evil, her peers were at parties, watching movies and being children – a privilege her position as “the chosen one” robbed her of. However, we as the viewer see a change at this time. No longer do her feet step into the night reluctantly as she has one eye on the kids at the party, but vigorously. Her nose alight with the scent of a blood sucking fiend, she no longer patrols, she hunts. This alone would not be too much of an issue, as on the surface it would just be her doing her duty willingly. But there is something else. Where she was dutiful before, reluctantly or willingly, now she has become obsessed with the thrill of the kill. Her thirst for destruction of these beasts becomes so great, it can hardly be separated from the bloodthirsty nature of the vampire. In the pursuit of destroying them, she has become more and more like them, and now she cannot stop. With her self-control out the window, the hunting becomes an addiction, and the cruel hungry predator in her takes over entirely. She and those around her decide that an intervention is required.

As with all good TV story lines, this prompts a vision quest. I am not very familiar with these first hand, but I glean from various sources that this is when someone is unleashed into the wild alone, usually fasted, in the hope this will lead to a vision (or hallucination) which will unlock an inner truth the person seeks and needs. Buffy undergoes the necessary rituals and finds herself in the desert of a spiritual plane. Before long she is confronted by an ominous mute presence. Although it does not speak, it is spoken for and describes itself as “destruction absolute.” Buffy quickly deduces that this entity is the spirit of the first slayer. The story goes that she was taken by three mages as a young girl and forced to consume demon energy to give her the strength to battle the forces of darkness. Unlike Buffy, the first slayer was ostracised from her community. Her power, her wrath was so great that although the human race needed her for protection, they could not understand her and in her presence feared for themselves. Despite being made to purge evil from the world, others could sense the rabid darkness in her which made her powerful – and they feared it greatly.

A spirit guide interprets for the predatory vision at first: “I am destruction, I am death. I am the slayer.” Eventually she verbalises “No friends, just the kill. We are alone.” Buffy, rather comedically at this point, informs the first slayer that she has friends, she

likes to shop and is to all intents and purposes, rather a normal teenage girl aside from the whole superhuman evil slayer thing. They engage in hand-to-hand combat which ends in them wrestling all the way down a sand dune, and Buffy waking up with the seemingly malevolent vision still stalking her, trying to kill her. I love it.

While the series is very dated, the whole arc is clear about what it's telling us about Buffy. The first slayer seems an almost senseless machine programmed to bring nothing but violent endings. It leaves her empty. Her heart, if there is one, has little but malice and anger. She is just like that which she is destined to hunt, a destroyer. Nothing else. Buffy on the other hand embraces friendship, love and all that can be offered by a middle-class life in a Californian suburb. As well as that, in her resides the malice, the hate and the destruction that emanates from something monstrously powerful.

Buffy sees that she has a beast in her. Instead of denying it, condemning it, she overpowers it and accepts it. By the end of her quest, we see her back in her own world hunting again - nostrils ablaze with the smell of stolen blood, feet quick in pursuit of the damned flesh, and gaze steady upon the immortal hunter that is about to become prey. Instead of condemning the anger and cruelty she feels bubbling inside, she accepts it and puts it to use against creatures who deserve it. Instead of thinking there is only light inside, she not only accepts the darkness innate in her but chooses to harness it where it can help her pursue a greater objective. The Slayer is whole again. It won't be long before she is in a shopping mall purchasing clothing and slurping a milkshake – or something '90s' like that.

There is something we can all take from this. Jung spoke of accepting the shadow as being an essential part of self-actualisation. If we cannot accept the darker parts of us, how can we grow? A supervisor of mine said something to me that I haven't forgotten. "It seems to me that we take patients much closer to their darkness than the light." I think he's right. Not only that, but I think it's important for us all to look into the abyss within and ask ourselves what is there.

It's funny, as a kid I was petrified of the dark. I used to feel paralysed without the light on, like I'd been mummified. Even as an adult I wasn't great with it, especially if nobody else was in the house. But since delving into psychotherapy, delving into myself, rooting around in the darkness I have found myself walking not comfortably, but curiously in the winter darkness. I'd have convinced myself a year ago I was ready for whatever beast might lunge out at me, but now I know this is but a fantasy. It has not only been accepting the darker part of myself which has freed me, but knowing that there's more than enough concealed truth inside to destroy the version of myself I have become attached to. It is not one false face and one true, or one thing inside that's the real me and another that is not. These are the types of thinking which leave us split, weak and fearful. It is only when you accept that you are all the things you see, all the things you do not, all the things you know and all the things you are yet to discover, that it visits for the first time. That indescribable feeling of knowing that when the day comes for you to walk into death, you will leave fear behind.

## Different doors, same mind

**Dr Jessie Muchoki**

CT3 in General Adult Psychiatry, South Essex Partnership University Trust



Just as one fairy door is different from another, so are no two sessions the same for any one patient. Tick tock, tick tock - as I wait for the clock to strike, I reflect on the session held the previous week. Quick check to make sure the chairs are well aligned. Oh no! The tissue box is empty. Time is tight. I dash to the storeroom for a fresh box. In one of my initial supervision sessions, my consultant made me aware of the vital role of that rectangular box of recycled paper in the room. It's intriguing how various psychodynamic interpretations come forth from the moment the therapist steps into the reception lobby to meet the patient. Even the walk down the corridor can be daunting. "Gentle pace!" I remind myself.

As the River Crana calmly flows into the North Atlantic without brimming over its banks, in each session we strive to provide a containing environment for our patients. I turn the door knob not knowing what to expect, or even hope for.



*Gorgeous photos taken on our last trip to Swan Park, Buncrana*

## Chat between Hamed Nagy (ST4 Dual CAMHS and Medical Psychotherapy Trainee) and AI (ChatGPT)

**Dr Hamed Nagy**

CAMHS, Leeds Community Healthcare

**Hamed Nagy:** Hi AI! I'm in the middle of my Dual CAMHS and Medical Psychotherapy training, working toward my CCT. It's a lot to manage. How can you help me during this journey?

**AI:** Hi Hamed! I'd be happy to help. I can assist by providing you with resources tailored to the different psychotherapy approaches you're studying, whether it's CBT, psychodynamic therapy, or systemic therapy. I can even create case scenarios for you to practice different interventions and deepen your understanding. For example, I could give you a case like a 14-year-old with social anxiety. We could explore CBT strategies to challenge negative automatic thoughts, or psychodynamic therapy to uncover unconscious fears related to early attachment experiences. I'd help you formulate and create a session plan. How does that sound?

**Hamed Nagy:** That sounds great! The case scenarios would be useful. What about when I'm working on case formulations or session plans? Can you help with that too?

**AI:** Absolutely! I can help you organize your notes, summarize them, and make sure you're covering all the key points. If anything's missing, I'll point it out and help you fill the gaps. I can also assist with planning your upcoming therapy sessions, ensuring they follow a structured approach based on the model you're using. For instance, if you're seeing a 12-year-old experiencing panic attacks, I could suggest a CBT session structure starting with psychoeducation, moving to cognitive restructuring, and later on, exposure work. I can even develop **personalized charts and worksheets** that suit the child's specific needs, such as thought diaries or behaviour tracking worksheets to use during the sessions. Do you find session planning challenging at times?

**Hamed Nagy:** Yes, especially when I'm learning different therapy models. That would be a huge help! What about testing my understanding? Can you help me check my progress?

**AI:** Definitely! I can create quizzes to test your understanding of core principles and theories. For example, if you're learning about systemic family therapy, I could quiz you on concepts like circular causality or family homeostasis. A sample question might be: "What role does triangulation play in maintaining family conflict?"

**Hamed Nagy:** Quizzes sound perfect! They'll help me stay on top of things. But I also need materials that match how I learn best. Sometimes I prefer visual aids, other times I need text or even audio. Can you help with that?

**AI:** Of course! I can personalize the materials to fit your learning style. If you need visual diagrams for complex concepts, or audio summaries to listen to on the go, I've got you covered. For example, if you're studying psychodynamic therapy and the concept of transference, I can create a visual flowchart to show how transference develops in the therapeutic relationship. Or, I can provide an audio summary you can listen to while commuting. I'll adapt to whichever format suits you best at the time. Does that flexibility sound like it would work for you?

**Hamed Nagy:** It would! I like switching between formats depending on what I'm learning. Can you keep helping after I get my CCT, when I start practicing?

**AI:** Definitely! Once you achieve your CCT, I can continue to support you by keeping you updated with the latest research, helping with your CPD tasks, and organizing your study materials. I can also assist with writing or editing any articles you might contribute to professional newsletters, like your autumn/winter Faculty edition. For instance, if you're exploring the latest research on attachment theory, I can help summarize journal articles or highlight key studies. If you're writing an article for a professional audience, I can help with editing to make sure it's polished. Does that sound helpful as you move into practice?

**Hamed Nagy:** That sounds perfect! Having support with research and professional tasks would really keep me on track. Thanks for being there throughout the whole process, AI!

**AI:** I'm glad to hear that, Hamed! I'll be here whenever you need—whether it's during training, when you're preparing for your CCT, or after you start practicing. I can assist you with organizing your client notes into structured case formulations or keeping you up-to-date on new psychotherapy models. And of course, I'll continue to help with **personalized materials**—like session worksheets or therapeutic charts—to make sure you have exactly what you need for your clients. Let me know how else I can help along the way!

## Conference review

### Psychodynamic Psychiatry Day: 'Trouble in mind – yours or mine? The location of disturbance in the patient clinician relationship'

**Dr Ioana Toma**

CT1 in Tees, Esk and Wear Valleys NHS Foundation Trust

W.R. Bion once postulated that *'However experienced we are we still know very little indeed about how to bring up children, of whatever age. We are beginning to know that we do not know – that is something'*, underscoring that every light of knowledge is mirrored by its inherent shadow of mystery in the patient-clinician relationship. Unknowingness, nevertheless, carries richness and meaning and constitutes a foundation upon which the therapeutic relationship is built. It is more widely accepted that competence does not equal certainty, and the experienced therapist has to make an effort to preserve a certain state of not-knowing if he is to remain open to endless understanding.

The psychological geography of mental health disturbance and the dynamism of this relational spatiality is a subtle, but pervasive phenomenon at the heart of every clinical encounter. The 8<sup>th</sup> Psychodynamic Psychiatry Day in 2024 aimed to explore, elucidate

and enthuse discussions around this complex theme. Jo O'Reilly, Medical Psychotherapy Faculty Chair and Sarah Markham, Expert by Experience, opened the Conference with a frank, but genuine remark that '*We are all patients at certain times of our lives*' and that the experience of being a patient/client in one's own therapy is paramount in learning how to hold the patient parts of oneself. Professional defences we are all faced with, often disguised as 'clinical boundaries', can reinforce the split between patient and clinician. The aim of this relational event was to emphasize human curiosity and vulnerability regardless of systemic roles and social hierarchies.

The morning session was opened by Dr Gwen Adshead, Consultant Forensic Psychiatrist and Psychotherapist, who presented one of the best-known of Tom Main's papers, 'The Ailment', from a contemporaneous perspective. Tom Main (1911-1990) was a psychiatrist and psychoanalyst who coined the term 'Therapeutic Community (TC)' and perhaps introduced the term 'special patient' following his group research whilst working at the Cassel Hospital. He noticed how a particular troubling clinical dynamic ensued between a group of 'difficult patients' and 'ardent carers' represented by nursing staff. He noticed a relationship of direct proportionality between the severity of patients' treatment resistance and staff burnout, which was reflected in high rates of sickness. This emotional equation is eloquently described in the paper as '*The sufferer who frustrates a keen therapist by failing to improve is always in danger of meeting primitive human behaviour disguised as treatment*'. As the patients were getting worse or not showing any signs of improvement, the nurses succumbed to despair, unable to accept the unfavourable prognosis and failure of treatment.

As a result of this, a retrospective qualitative study which could well have been one of the first reflective practice groups, was set up to look at the psychodynamics of caring relationships. Negative feelings towards the patients were quickly fended off and transformed into individual defences such as rescue fantasies, splitting, therapeutic nihilism, denial of hatred and fear, envy and competitiveness. Dr Adshead extrapolated these findings to current institutional dynamics and wondered whether disturbance can be located in the staff, in the patients, within the system, or whether it is an invisible fabric interweaving strands of various internal spaces?

I found this reflection to be immensely revelatory regarding our unconscious motivations to venture into a care-giving profession such as psychiatry. As Dr Adshead points out in another paper, compulsive care-giving behaviour is hypothesised to result from insecure attachment representations<sup>1</sup> and many people who provide mental healthcare are suffering. The ending, on the note that transformation of suffering is key to all psychotherapies, reminded me of a quote by Richard Rohr, an American Franciscan priest: '*If we don't transform our pain, we will most assuredly transmit it*'.

A facilitated discussion between clinicians and experts by experience on Defence mechanisms and their symbolic utility followed, chaired by Tom Ayers, Director of the National Collaborating Centre for Mental Health. Drawing upon the dichotomy of '*Us and them: Is it a necessity or a cause of harm?*' this was a fascinating conversation ranging from the use of diagnostic labels as an attempt to categorise suffering, to the function of language, and attribution of emotional difficulties solely to service users, which leads

to iatrogenic harm. The ultimate sin of 'swapping tribes' was debated by experts by experience whose identity could be both a mental health professional and a patient. It was agreed that the diagnosis *per se* is less about a disorder, but more about someone being chosen to be a container for organisational defences, organisations which are at times unable to grapple and stay with not-knowing. Working as allies means accepting there is no '*us against them*', which often is the illusion of invulnerability, but '*us against the problem*'.

Dr Benji Waterhouse, Consultant Psychiatrist and award-winning comedian, read from his book '*You Don't Have to Be Mad to Work Here: a Psychiatrist's Life*' two striking cases demonstrating the immense value in abandoning the stance of psychiatrist for that of an unguarded human being. It is not uncommon to force patients to align with our own versions of reality to facilitate our understanding and medicalise eccentric behaviour, states of affairs dealt with, with humour and lucidity in the book. Who is the healer and who is doing the healing in any therapeutic encounter when an emotional storm is created?

Returning to the first session's metaphorical pillar of TC, the day ended with a community meeting group from the Cassel Hospital. Psychiatrists, nurses and former patients gathered to shed light on the emotional implications of difficult conversations and how fluidity of boundaries can have a regenerating effect on relationships, rather than a destructive one. A non-hierarchical, democratic system of care was explored in the light of sensitive topics, such as challenging authority and assumptions, elucidating the meaning of 'high risk patients' and candid disclosures in propitious conditions. Acrimony between members was tackled with more mature defence mechanisms such as humour, altruism and suppression. What could have been a potentially perilous situation crystallized into a lesson of rupture and reparation, and I highly admired the cohesion of the group reflecting the humanity of all members. I found the demonstration to be an incredible example of what '*community*' truly means: having and holding a sense of responsibility for the feelings of individuals and by extension for the community. The nurturing of this emotion continues long after discharge from hospital; unfortunately, perpetuation of this dynamic outside the establishment has been weaponised against patients whose attachment to the institution might have been the only consistent bond they had throughout their lives.

By the end of the Conference, I felt an intimate attunement to the emotional and intellectual climate created by the speakers and the questions from the public. This reminded me of the necessity to ask ourselves the question we pose to patients and clients, '*What brings you here?*', a fascinating theme also investigated in depth in '*The Myth of the Untroubled Therapist*' by Marie Adams. I mentioned this book as it echoes most of the themes presented through the day and points out that it is the *relationship* that matters, and it is within the relationship that we can hope to know ourselves as much as we hope to know others.

**References:** Adshead G. Becoming a caregiver: attachment theory and poorly performing doctors. *Med Educ.* 2010 Feb;44(2):125-31. doi: 10.1111/j.1365-2923.2009.03556.



## Book and Film Reviews

### FILM: A Different Man

2024. Director: Aaron Schimberg

**Dr Sahdeea Sultana**

CT3 in Psychiatry, East London NHS Foundation Trust

The film *A Different Man* stars Sebastian Stan as Edward, who undergoes a mysterious procedure to cure his facial disfigurement which he has grown comfortable with and lived with, within his perceived limitations.



I suspect this to be a little-known film amongst colleagues; with the onslaught of films recently, which have more publicity addressed similar themes, this would be easy to overlook – e.g. *The Substance*, which sees a woman undergo a dystopian cure to the ageing process and the consequences that result. An eerie and echoing slogan from this movie “You are one” could also be applied to the protagonist of *A Different Man* - there is a unifying link to his pre- and post-procedure self - himself.

*A Different Man* is a gentler and subtler study of the aftermath of such a process to the individual's reception in the world, and also of the relationship with himself. Does (quite literally) shedding his external skin provide a cure for the disturbances in the psyche too? In other words, can man really outrun his nature and how much of this was really informed by his appearance?

There are two motifs to pay attention to which are metaphorically significant. The first is a roof leak which starts small and is ignored by the protagonist. Gradually the growing rot and decay cannot be overlooked and he is forced to face it. The second is a ‘souvenir’ mask of the original disfigurement, which out of desperation we find him hiding behind once again, seeking out or craving the same responses he had before his procedure, as if providing an external salve to his inner distress. The ‘cure’, we learn, has not cured his psychological constellation, which is still married to his former self.

Ethically we could reflect upon the responsibility of the clinician in providing such a procedure, causing a drastic external change without some subsequent reintegration process, such as counselling or therapy. It highlights how our bodies and minds are connected and a change in the body without an adaptation of the psyche may lead to disturbance, here portrayed in extremis. In contrast, in the aforementioned *The Substance*, the elixir is sought in the black market, and the dispenser at least forewarns of the cognitive dissonance that may follow.

We also meet Edward's doppelgänger of his pre-procedure self, and the effortlessness and the likeability of the character who despite being dealt a similar hand with his physical condition has managed to create meaning and fulfilment, serves further to emphasise the psychological descent of Stan's protagonist.

I found it a fascinating character study with rich material for psychoanalytic discussion and reverie. A pleasure to watch.

## FILM: Manchester by the Sea

2016. Director: Kenneth Lonergan

**Dr Aashna Singh**

CT2, TEWV NHS Foundation Trust, North East England



'Manchester by the Sea' (2016), directed by Kenneth Lonergan, is a profoundly affecting exploration of grief, trauma, and emotional isolation. This Oscar-winning film follows Lee Chandler (Casey Affleck), a janitor in Quincy, Massachusetts, who is called back to his hometown of Manchester-by-the-Sea after the sudden death of his brother, Joe (Kyle Chandler). What follows is not just a logistical drama of handling Joe's affairs and caring for his teenage nephew, Patrick (Lucas Hedges), but an unflinching portrayal of one man's journey through the long shadows of unbearable personal tragedy.

At its core, 'Manchester by the Sea' is an intimate character study that examines how people cope with immense emotional pain. The film stands apart for its quiet, understated realism, where the

rawness of grief is portrayed not through melodrama or extreme narrative twists but through the simple, everyday moments of life. It invites the audience to sit with discomfort and wrestle with the complexities of unresolved trauma, themes particularly relevant to the field of psychiatry, where professionals often deal with the long-lasting and deeply personal impact of trauma and loss on mental health.

### A Haunting Study of Trauma

One of the most striking aspects of 'Manchester by the Sea' is its portrayal of Lee Chandler's response to trauma. The film slowly reveals that Lee is not just mourning the loss of his brother but is carrying the heavy burden of a past tragedy involving the accidental deaths of his three children, for which he holds himself responsible. This tragic event is presented in a series of flashbacks, a storytelling technique that allows

the viewer to piece together Lee's story in fragments, much like how people with trauma often revisit their past in nonlinear, intrusive ways.

Lee's grief is not dramatic or performative; it is quiet and internal, manifesting in his stoic, detached demeanour. Casey Affleck's Oscar-winning performance conveys a man so consumed by guilt and sorrow that he has shut down emotionally. He has become a hollow version of his former self, barely engaging with the world around him. As Lee navigates his brother's death and the possibility of becoming Patrick's guardian, the film does not offer a neat redemption arc. Instead, it portrays the persistent and overwhelming nature of trauma, a burden that Lee cannot simply "overcome."

From a psychiatric perspective, Lee's emotional state is a textbook example of what we might recognise as complicated grief or post-traumatic stress disorder (PTSD). His symptoms align with what clinicians often observe in individuals who have experienced profound loss and trauma—numbness, avoidance, and emotional withdrawal. The film also touches on substance use as a coping mechanism; Lee is shown drinking heavily in the aftermath of his personal tragedy, hinting at the relationship between trauma and maladaptive coping strategies.

As psychiatrists, it is essential to understand how trauma can reshape a person's internal and external world. Lee's character shows that grief and trauma are not linear processes. They linger, often for years, and can profoundly impact an individual's ability to re-engage with life. 'Manchester by the Sea' avoids any simplistic notion of "moving on" and instead shows that, for some, the best they can manage is learning to live alongside their pain.

### **The Complications of Grief and Familial Obligations**

Another central theme of the film is the tension between personal grief and familial obligation. After Joe's death, Lee is thrust into the role of Patrick's guardian. Patrick, in contrast to Lee, appears to be handling his father's death with surprising resilience, maintaining his busy social life, juggling girlfriends, and trying to hold onto his sense of normalcy. However, this is not to say that Patrick is unaffected; he has his own complex relationship with grief, marked by episodes of panic and emotional outbursts, such as his breakdown when a frozen chicken reminds him of his father's body being kept in a freezer awaiting burial.

The film skilfully portrays the different ways in which people process loss. Patrick's outwardly functional behaviour may seem at odds with Lee's emotional paralysis, but it speaks to the varied ways individuals cope with death. This contrast is a subtle reminder to mental health professionals of the diversity in grief reactions, particularly in adolescents. Patrick's mix of defiance, humour, and vulnerability reflects the multifaceted nature of teenage grief, a topic often overlooked or misunderstood in clinical settings.

The relationship between Lee and Patrick also highlights the complexity of familial roles in the context of grief. Lee, who is consumed by his own pain, struggles to provide the emotional support Patrick needs. At one point, Lee admits, "I can't beat it. I can't beat

it. I'm just not capable." This confession of his emotional limitations underscores the theme that, sometimes, the people we expect to offer support in times of crisis are the ones least capable of doing so. From a psychiatric lens, this dynamic mirrors the challenge faced by families when a primary caregiver or family member is incapacitated by their own emotional struggles.

### **The Setting as a Reflection of Internal States**

The cold, wintry landscapes of Manchester-by-the-Sea serve as an evocative backdrop for the film's themes of isolation and emotional desolation. The harsh New England winter, with its icy waters and barren streets, mirrors Lee's internal world - frozen, inhospitable, and stuck in a state of perpetual mourning. The setting reinforces the sense that Lee is trapped, both geographically and emotionally, unable to escape the town where his worst memories reside.

From a psychiatric perspective, the film's setting can be seen as a metaphor for Lee's depressive state. He is inextricably bound to Manchester-by-the-Sea, much like individuals with depression often feel tethered to the places or circumstances that contributed to their emotional suffering. The isolation of the small town also reflects the isolation Lee feels from the people around him, even those who want to help him. His refusal to move forward, despite the opportunities presented, speaks to the immobilising effect of grief and trauma.

### **Conclusion: A Realistic Portrayal of Grief's Complexity**

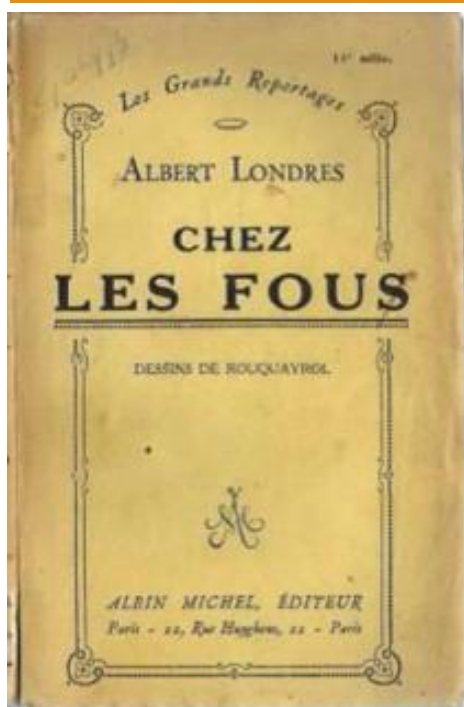
'Manchester by the Sea' is not an easy film to watch. It offers no tidy resolutions or cathartic moments of closure. Instead, it presents a hauntingly realistic portrayal of grief as a lifelong companion to those who have experienced profound loss. For professionals in the mental health field, the film serves as a powerful reminder of the complexities of trauma and the varied ways in which individuals cope with grief.

The film's refusal to provide simple answers is perhaps its greatest strength. It acknowledges that some wounds are too deep to heal completely and that some people, like Lee, may never fully recover from their losses. But in its quiet, unvarnished realism, 'Manchester by the Sea' also offers a glimpse of how people can continue to live, even when burdened by immense emotional pain. For psychiatrists and mental health professionals, this film provides a nuanced exploration of the human condition, making it a valuable watch for those seeking to understand the long-term impacts of grief and trauma.

## BOOK to be reviewed: "Chez Les Fous" (1925) by Albert Londres

**Dr Stephen Wilson**

Psychiatrist, critic, writer and translator, Oxford



If anyone is interested in reviewing this book, which I translated from the French, I'd be happy to provide an electronic copy or hard copy if desired.

"Chez Les Fous" (1925) by Albert Londres is a little gem, about 25,000 words, and has many quaint illustrations in it by Rouquayrol (some examples below). Both text and illustrations are now in the public domain, and I have written an introduction putting the book into context and footnotes explaining some French references.

Londres was a popular writer in his time, credited with the invention of 'investigative' journalism. To produce the book he gained access to a variety of asylums, clinics and "madhouses" and was able to speak with both staff and inmates. Much of what he observes is both poignant and shocking. I have

translated the title as **With** the Mad, because it indicates that Londres was both among the mad and "on their side". The book paints a convincing picture of "madness" and the state of mental health care at the time.

### Excerpt from Foreword:

"Londres' sympathy was with the wretched of the world, misfits, outcasts, unfortunates, victims of social injustice, colonialism and governmental maladministration. He rejected the hypocrisy of self-satisfied bourgeois morality, content to sweep unpleasant truths, far off cruelties, social deprivation, and the horrors of war under the carpet. In his short life he bore witness to the Balkan Wars, the First World War and the Sino-Japanese War. His dispatches concerning revolution in Russia, Jewish immigration in the Middle East, French penal colonies in Africa and the exploitation of prostitutes in Buenos Aires, produced record sales for his employers. His view of his calling is best summarised in his own words:

*'A journalist isn't a choirboy and his role does not consist in leading processions with his hand dipped in a basket of rose petals. Our professional duty is not to give pleasure, nor to do harm, it is to stick our pen into the wound.'*

He could have added, 'having first injected a syringe full of ironic humour'."

**Stephen Wilson** is a psychiatrist, critic, writer and translator, who has lived and worked in Oxford, UK, for many years. He is also the author of brief biographical studies of the first world war poet *Isaac Rosenberg*, and *Sigmund Freud*. In addition he has written *The Bloomsbury Book*



of the Mind (Bloomsbury 2004), *Introducing the Freud Wars*, *The Cradle of Violence: Essays on Psychiatry, Psychoanalysis and Literature*. He has contributed numerous reviews and articles to journals and newspapers including *Encounter*, *TLS*, *The Guardian*, *The Independent* and *New York Times*. His most recent academic publication is "Study on the Szaszophone: Theme and variations" in *Thomas Szasz: An Appraisal of his Legacy*, Ed. C.V. Haldipur et al (2019) Oxford University Press. His most recent translation is *Térésa and Other Women* by Albert Memmi.



## 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.

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 contribution.

We may be able to negotiate access to review copies in some cases. Please therefore, if this is something that interests you, send an email to the editor, Pamela Peters [pamela.peters@cpft.nhs.uk](mailto:pamela.peters@cpft.nhs.uk).

## Poetry/Art

### On a psychiatrist's workplace trauma

**Sharon Kwagiri**

CT2 Psychiatry, Harrogate Learning disability Service, Tees, Esk and Wear Valleys NHS Foundation Trust



In all the corners of me, a sea of emotions flow.

I feel it but can't show it.

I signed up for the job and daily I'm reminded of this.

These scars from you I must bear.

I take you home with me, I must bear my cross.

Now I see my loved ones bear the cross;

In all the corners of them too.

I came to help, but now I must be helped.



## Events, notices & dates for your diary

### BPA Events

Luke Perry  
BPA

## The Introductory Lectures Series

**Start:** 10<sup>th</sup> January 2024 8 pm – 9.30pm

**End:** 3<sup>rd</sup> July 2024 (two terms)

Online, via Zoom

**Cost:** £35 - £550 | individual lectures, a set of 5 or terms can be signed up to (student and NHS trainee discounts available)

This series of lectures introduces fundamental psychoanalytic ideas and explores a range of topics in greater depth. Delivered by BPA Psychoanalysts, presentations are followed by a group discussion.

The series is organised so as to build up a systematic knowledge of the field over two academic terms or self-contained lectures that can be attended individually. Whether you already have some understanding of psychoanalysis or are simply curious, we hope that these lectures convey a sense of contemporary psychoanalytic thinking as well as what it is like to practice as an Analyst in 2023.

Click here to register: [The Introductory Lectures Series – BPA \(psychoanalysis-bpa.org\)](https://www.bpa.org.uk/psychoanalysis/the-introductory-lectures-series)



**STARTS: JANUARY 2025 Monday evenings 8-9.30 pm Online on Two-term course: Term 1: 6 January - 7 April 2025 | Term 2: 28 April - 7 July 2025**

**Fees: £650 for two terms £550 with concessions**

**Deadline for applications: 30 November 2024**

The Pre-Foundation Course offers an introduction to contemporary psychoanalytic theory and the opportunity to explore how this applies in the consulting room and to everyday life. No previous knowledge or clinical experience is necessary although people from the mental health professions do also attend.

Some of the subjects we will explore include what Psychoanalysis is and how it differs from other forms of psychotherapy. We will think about: the psychoanalytic setting conscious vs unconscious communication and how we listen for unconscious communication what transference is, how it is experienced and why it is important. We will consider how early experience impacts later patterns of relating, what ego defences are and how they manifest as well as explore the Oedipus Complex from a contemporary standpoint.

**Further information and to apply:** [psychoanalysis-bpa.org/pre-foundation-course](https://psychoanalysis-bpa.org/pre-foundation-course)



**STARTS: JANUARY 2025 Monday evenings 8-9.30 pm Online on Two-term course: Term 1: 6 January - 7 April 2025 | Term 2: 28 April - 7 July 2025**  
**Fees: £800 for two terms £700 with concessions**  
**Deadline for applications: 30 November 2024**

The Foundation Course offers the opportunity to gain a deeper understanding of psychoanalytic theory and clinical practice during a series of 20 online seminars. Each set of 5 seminars will be led by a different pair of BPA analysts introducing the participants to a variety of approaches and styles.

We will be reading key papers from the field and discussing clinical material so previous knowledge of psychoanalytic ideas, relevant clinical experience and having had some personal therapy is required. Each seminar will be led by a pair of experienced BPA analysts with the aim of exploring key concepts as illustrated by case material thereby linking theory with practice, deepening our understanding.

**Further information and to apply:** [psychoanalysis-bpa.org/foundation-course](https://psychoanalysis-bpa.org/foundation-course)

**Other BPA events:** [Events | Institute of Psychoanalysis](#)

## Faculty Group

The group for consultants and higher trainees in Medical psychotherapy continues to meet on the fourth Thursday of the month at 5.30-7pm. If you would like to join, please contact Dr Mark Morris on [mpfacultylargegroup@gmail.com](mailto:mpfacultylargegroup@gmail.com).

## Supporting QI with the Accreditation Programme for Psychological Therapies Services (APPTS)

Jemini Jethwa, Programme Manager  
Josh Coelho, Project Officer

### Who we are and what we do

The Accreditation Programme for Psychological Therapies Services (APPTS) was established in 2014 and is now one of just under 30 networks within the CCQI. APPTS is a collaboration between The College Centre for Quality Improvement (CCQI), the British Psychological Society, clinical experts within member services, and the lived experience of people that have accessed psychological therapies services.

On APPTS, our key objectives are to help psychological therapies services to evaluate themselves against agreed standards, award accreditation to services that meet the required level of performance, support local clinical and service improvement in line with the standards, and to enable sharing of good practice across services.

Services that are awarded accreditation can assure service users, carers, staff, commissioners, managers and regulators that their psychological therapies service is of a good quality and that staff are committed to improving care. Accreditation also rewards hardworking psychological therapy service staff for their efforts, and raises morale and the profile of the team within the wider organisation.

### Our standards

The standards against which services are measured have been developed with reference to the literature, current guidance on best practice, and in consultation with key stakeholders including service users, practising therapists, service leads and professional organisations that therapists belong to. There are additional standards for services that are part of the NHS Talking Therapies for Anxiety and Depression programme. The standards are revised regularly and signed off by the CCQI following feedback from participating services and other stakeholders.

### Types of APPTS membership

*Accreditation:* Designed for services which are already meeting the majority of APPTS standards and can demonstrate that they are meeting the required thresholds for accreditation.

*Developmental:* A starting point membership for all services that are new to APPTS, or for services that are still working towards meeting the sufficient thresholds for accreditation. This membership option is also open to international psychological therapies services.

*Affiliate:* For psychological therapies services that are not ready to undergo the APPTS peer review process but have plans to in the near future. Services will gain access to all membership benefits including events, publications, networking opportunities and support from peers.

### **The peer review assessment process**

The peer review process starts with a self-review assessment over a period of 12 weeks. This is an opportunity for a psychological therapies service to rate themselves against the APPTS standards, stating whether they think they meet the standard or not. This assessment also includes online questionnaires to be completed by therapists and service users.

A review team made up of at least two psychological therapies service professionals from other APPTS member services, a patient or carer representative and a member of the central APPTS team then visit a service to discuss and validate their self-review data. The data collected from both the self- and peer review is used to write a comprehensive local report, which highlights the service's achievements and outlines changes needed in order to meet any unmet standards.

For teams that wish to be awarded accreditation, their report and further evidence is presented to the APPTS Accreditation Committee, who review the evidence and make decisions relating to accreditation. If awarded accreditation, the award lasts for a period of three years. Teams are given time, guidance and support to reach accreditation by both the Accreditation Committee and APPTS team.

### **Working with patients and carers**

The CCQI strongly advocate for the involvement and engagement of people with lived experience in all Quality Networks or Accreditation Programmes. APPTS is lucky enough to have two representatives with lived experience that feed into the work of the programme. The BPS also appoint a lived experience representative to sit on the APPTS Advisory Group. Lived experience representatives are involved in attending reviews, revising standards, making accreditation decisions on our Accreditation Committee (AC), advising on the developments of the network on the Advisory Group (AG), chairing events and contributing to publications.

### **Sharing learning through special interest days**

APPTS began hosting special interest days in 2022 based on feedback from members that they would like more networking opportunities. Topics covered:

- *Barriers to accessing psychological therapies services* which took place in 2022, covering age, gender and sexuality as barriers to accessing psychological therapies services; student access to psychological therapies services; and removing barriers to psychological therapies via collaboration with lived experience representatives.
- *Working systemically with families and communities* in 2023, which covered the ethnic inequalities policy review, implementing the triangle of care within non-NHS psychological services and the family intercultural systemic approach.
- *Trauma-informed care* in 2024, covering what we mean by trauma-informed care, enhancing trauma-informed care and the principles of trauma-informed care.

We tailor upcoming events based on suggestions from psychological therapies services. Anyone is welcome to attend these events and should contact us or see our website if they would like to know more.

### How can you get involved?

We welcome any service that is interested in becoming a member of APPTS to get in touch with us. In addition, we hold several training sessions a year, which are free for all staff in our member services to attend. We would encourage any services that have not yet completed the training, to attend and qualify as peer reviewers to gain insight into how other psychological therapy services are operating. Information about our upcoming events and training is on our website.

For more information about the programme, please access our [website](#) or contact us at [APPTS@rcpsych.ac.uk](mailto:APPTS@rcpsych.ac.uk)

Tel: 0208 618 4061

The Royal College of Psychiatrists, 21 Prescot Street, London, E1 8BB

## Introducing the first RCPsych Psychopharmacology Committee Newsletter!

Calling all members with an interest in psychopharmacology!

[Sign up now](#) to receive it and learn about:

Why Trainees Should Be Interested in Psychopharmacology, Prescribing Wisely: Using Existing Treatments Better , A Lived Experience Prospective, KarXT a new FDA approved drug for schizophrenia and much more!

Our goal is to create an essential psychopharmacology resource for all psychiatrists, with relevant updates, insights, and learning opportunities, and to keep members informed on the latest Psychopharmacology hot topics and the activities from the committee.

Each issue, **expected once a year**, will feature a range of engaging topics, including:

- Why psychopharmacology is vital for psychiatry trainees and sources of educational opportunities
- A "Prescribing Wisely" section updating members on latest treatment guidance
- Latest news from the Prescribing Observatory for Mental Health (POMH) and the Medicines and Healthcare products Regulatory Agency (MHRA)
- Summaries of groundbreaking research findings
- Lived experience perspectives
- Other recent work from our Psychopharmacology Committee

## Call for submissions

My grateful thanks to all who have contributed to this newsletter. Please continue to send in contributions over the next few months for the spring/ summer edition. The deadline for submissions is **14<sup>th</sup> February 2025**.

All contributions can be sent to me at [pamela.peters@cpft.nhs.uk](mailto:pamela.peters@cpft.nhs.uk).